

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

Olympia, Washington 98504

APPLICATION FOR CERTIFICATE OF NEED
Hospital Projects

(Excluding Sale, Purchase or Lease of Hospital, Nursing Home Related Projects, and CCRC Related Projects)

Certificate of Need applications must be submitted with a fee in accordance with Washington Administrative Code (WAC) 246-310-990 and the instructions on page 2 of this form.

Application is made for a Certificate of Need in accordance with provisions of Chapter 70.38 Revised Code of Washington (RCW) and Rules and Regulations adopted by the Department (WAC 246-310). I hereby certify that the statements made in this application are correct to the best of my knowledge and belief.

APPLICANT(S)

<p style="text-align: center;">(PLEASE PRINT OR TYPE)</p> <p>OWNER:</p> <p>Name and Title of Responsible Officer: Kim Williams, Board Member Northwest Washington Rehabilitation Hospital, LLC</p> <hr/> <p>Signature of Responsible Officer: <i>Kim Williams, CEO</i></p> <p>Date: <u>5/6/19</u> Telephone Number: <u>425-261-4288</u></p> <hr/> <p>Name and Title of Responsible Officer: Martin Mann, Board Member Northwest Washington Rehabilitation Hospital, LLC</p> <hr/> <p>Signature of Responsible Officer:</p> <hr/> <p>Date: _____ Telephone Number: _____</p> <hr/> <p>Legal Name of Owner: Northwest Washington Rehabilitation Hospital, LLC</p> <hr/> <p>Address of Owner: <u>680 South Fourth Street</u> <u>Louisville, KY 40202</u></p>	<p style="text-align: center;">(PLEASE PRINT OR TYPE)</p> <p>OPERATOR:</p> <p>Name and Title of Responsible Officer: Kim Williams, Board Member Northwest Washington Rehabilitation Hospital, LLC</p> <hr/> <p>Signature of Responsible Officer: <i>Kim Williams, CEO</i></p> <p>Date: <u>5/6/19</u> Telephone Number: <u>425-261-4288</u></p> <hr/> <p>Name and Title of Responsible Officer: Martin Mann, Board Member Northwest Washington Rehabilitation Hospital, LLC</p> <hr/> <p>Signature of Responsible Officer:</p> <hr/> <p>Date: _____ Telephone Number: _____</p> <hr/> <p>Legal Name of Operator: Northwest Washington Rehabilitation Hospital, LLC</p> <hr/> <p>Address of Operator: <u>680 South Fourth Street</u> <u>Louisville, KY 40202</u></p>
<p>TYPE OF OWNERSHIP:</p> <p><input type="checkbox"/> District</p> <p><input type="checkbox"/> Private Non-Profit</p> <p><input checked="" type="checkbox"/> Proprietary – Corporation</p> <p><input type="checkbox"/> Proprietary – Individual</p> <p><input type="checkbox"/> Proprietary – Partnership</p> <p><input type="checkbox"/> State or County</p>	<p>OPERATION OF FACILITY:</p> <p><input checked="" type="checkbox"/> Owner Operated</p> <p><input type="checkbox"/> Management Contract</p> <p><input type="checkbox"/> Lease</p>
<p>Proprietor(s) or Stockholder(s) information: Provide the name and address of each owner and indicate percentage of ownership:</p> <p><u>Kindred Development 12, LLC (51%)</u> <u>680 S. Fourth Street Louisville, KY 40202</u></p> <p><u>Providence Health & Services-Washington</u> <u>dba Providence Regional Medical Center Everett (49%)</u> <u>1700 13th Street Everett, WA 98201</u></p>	<p>TYPE OF PROJECT (check all that apply):</p> <p><input checked="" type="checkbox"/> New Health Care Facility</p> <p><input type="checkbox"/> Bed Addition</p> <p><input checked="" type="checkbox"/> New Tertiary Health Service</p> <p><input type="checkbox"/> Pre-Development Expenditure</p> <p><input type="checkbox"/> Other</p>

Intended Project Start Date:
November 2019 or upon CN Approval

ESTIMATED CAPITAL EXPENDITURE:
\$3,000,000

Project Description: Northwest Washington Rehabilitation Hospital, LLC proposes to establish a 40-bed inpatient rehabilitation hospital.

INSTRUCTIONS FOR SUBMISSION: DO NOT bind your application. Bindings, notebooks and other covers are not necessary. Please number the pages at the bottom, and two-hole punch the application material at the top of the pages.

1. Mail two copies of the completed application, with narrative portion to:

**Department of Health
Certificate of Need Program
PO Box 47852
Olympia, Washington 98504-7852**

The application must be accompanied by a check, payable to: ***Department of Health.***

2. COMPLETE THE FOLLOWING PRIOR TO SUBMISSION FOR REVIEW:

TOTAL AMOUNT OF FEE ACCOMPANYING THIS APPLICATION:

REVIEW FEE: \$40,470

APPLICANT NAME: Northwest Washington Rehabilitation Hospital, LLC

DATE OF SUBMISSION: May 15, 2019 CHECK NUMBER:¹ 09963872

¹ Please see Exhibit 1 for a copy of the check to the Department of Health.

**Northwest Washington Rehabilitation
Hospital, LLC**

Certificate of Need Application

**Proposing to Establish a 40-bed Inpatient
Rehabilitation Hospital**

May 2019

Table of Contents

Introduction and Rationale.....	1
I. Applicant Description.....	4
II. Facility Description.....	6
III. Project Description.....	9
IV. Project Rationale.....	20
A. Need (WAC 246-310-210).....	20
B. Financial Feasibility (WAC 246-310-220).....	35
C. Structure and Process (Quality) of Care (WAC 246-310-230).....	42
D. Cost Containment (WAC 246-310-240).....	47

Table of Tables

Table 1. PRMCE Medicare and Medicaid Provider Numbers.....	5
Table 2. Historical Occupancy at PRMCE Rehabilitation Unit.....	7
Table 3. Projected Operating Expenses.....	10
Table 4. Northwest Washington Rehabilitation Hospital - Projected Utilization.....	11
Table 5. Square Footage by Department	15
Table 6. Historical Occupancy at PRMCE Rehabilitation Unit.....	21
Table 7. Snohomish County Planning Area. Historic and Forecast Resident (Ages 15+) Population Figures, 2010-2035.....	22
Table 8. Snohomish County Planning Area Rehabilitation Bed Need Forecast, Inpatients 15 years of Age and Older, 2017-2032.....	22
Table 9. PRMCE and Puget Sound Region Charity Care 2014-2016.....	30
Table 10. Northwest Washington Rehabilitation Hospital - Projected Utilization.....	32
Table 11. Northwest Washington Rehabilitation Hospital - Estimated Project Costs.....	35
Table 12. Northwest Washington Rehabilitation Hospital - Sources of Financing.....	36
Table 13. Northwest Washington Rehabilitation Hospital - Projected Startup Costs.....	37
Table 14. Northwest Washington Rehabilitation Hospital - Projected Sources of Revenue.....	40
Table 15. Kindred Rehabilitation Hospital Clinical Quality Indicators	45

Table of Figures

Figure 1. Kindred's Joint Venture Experience.....	18
Figure 2. Snohomish County Planning Area Use Rate Regression Analysis.....	26

Table of Exhibits

Exhibit 1. CN Application Filing Fee Check	
Exhibit 2. Letter of Intent	
Exhibit 3. Northwest Washington Rehabilitation Hospital, LLC – Secretary of State Registration	
Exhibit 4. Organizational Structure - Providence Health & Services, Kindred Healthcare, LLC and Northwest Washington Rehabilitation Hospital, LLC	
Exhibit 5. Facility Listings	
Exhibit 6. Snohomish County Planning Area Definition and Map	
Exhibit 7. Kindred Funding Letter	
Exhibit 8. Site Purchase Agreement	
Exhibit 9. Developer Term Sheet	

- Exhibit 10. Equipment List
- Exhibit 11. Single Line Drawings
- Exhibit 12. Documentation of Zoning
- Exhibit 13. Kindred Healthcare 2018 Quality Report
- Exhibit 14. Bed Need Model
- Exhibit 15. Providence Regional Medical Center Everett Charity Policy
- Exhibit 16. Providence Regional Medical Center Everett Admissions Policy
- Exhibit 17. Providence Regional Medical Center Everett Nondiscrimination Policy
- Exhibit 18. Providence Regional Medical Center Everett Patient Origin Analysis
- Exhibit 19. Kindred Rehabilitation Hospitals – Utilization Growth Examples
- Exhibit 20. Proforma Financials
- Exhibit 21. Staffing Schedule
- Exhibit 22. Providence Regional Medical Center Everett Nondiscrimination Policy

Table of Appendices

Appendix 1. Audited Financials: Providence Health & Services-2015;
Providence St. Joseph Health-2016, 2017

Appendix 2. Audited Financials: Kindred Healthcare, Inc.–2016, 2017;
Kindred Healthcare, LLC-2018

**State of Washington
Department of Health
Application for Certificate of Need**

Introduction and Rationale

Northwest Washington Rehabilitation Hospital, LLC (“NWRH” or “Applicant”) is requesting Certificate of Need approval to establish a freestanding 40-bed acute inpatient rehabilitation hospital in Snohomish County. NWRH is a joint venture between Providence Health & Services – Washington (“Providence”) D/B/A Providence Regional Medical Center Everett (“PRMCE”) and Kindred Development 12, LLC (“KND12”).² The current request is an integral part of Providence and Kindred’s shared goal of providing comprehensive, state-of-the-art inpatient rehabilitation services to Snohomish County residents.

Established in 1978, PRMCE’s inpatient rehabilitation unit is currently licensed to operate 19 Level II Rehab beds, and Kindred has been providing management services for the unit since 2010. The unit provides rehabilitation for individuals diagnosed with stroke, brain injury, spinal cord injury and other diagnoses. Establishing a new freestanding inpatient rehabilitation hospital in Snohomish County combines Providence’s reputation as a trusted provider of high quality medical care with Kindred, an experienced provider of inpatient rehabilitation services with proven success in local community partnerships and history of service to Western Washington. The new 40-bed inpatient rehabilitation hospital will improve access for area patients requiring inpatient rehabilitation services in the Planning Area.

The proposed hospital is specifically designed to create an exceptional healing environment for rehabilitation patients. A state-of-the-art facility with a designated patient room area for stroke and traumatic brain injury patients enables clinical staff to more effectively care for the unique medically-complex needs of these special patient populations. The hospital will have a large therapy area with a full spectrum of equipment for physical and occupational therapy and an apartment for patients to practice using common household items and appliances in order to build strength, skills and confidence to accomplish important tasks prior to discharge.

Due to the need for additional inpatient rehabilitation beds in the Planning Area and the high population growth rate for residents 65+ years old, PRMCE and Kindred currently face challenges in their ability to provide care for the growing community. The proposed addition of a new 40-bed inpatient rehabilitation facility responds to current utilization trends and addresses the future need in the Planning Area to serve the residents’ increasing health care needs.

Rehab Bed Need Methodology

In the case of acute care bed requests, the methodology used to estimate the need for future acute care beds is defined in the hospital bed need forecasting methodology in the Washington State Health Plan (“SHP”). Since there is no rehabilitation-specific methodology defined in the SHP or by the Department, the acute care forecast model has been used and modified to reflect adult rehab days and use rates only. According to the Forecasting Method, there is a net demand for 5.2 beds in 2017, 11.5 beds in 2024, and 18.5 beds by 2032. This net demand is on top of the 19 existing rehabilitation beds at PRMCE that will be transferred to the new facility. When combined together, these

² Kindred Development 12, LLC is a subsidiary of Kindred Healthcare, LLC (“Kindred”).

demonstrate a total need of 37.5 beds in the Planning Area. There are no other inpatient rehabilitation facilities in the Planning Area.

Planning Area Growth

The Planning Area population aged 15+ grew 1.2% annually over the 2010-2015 period and is expected to grow by 2.1% over the 2015-2020 period, and continue between 1.5% to 1.2% between 2020 and 2035. This growth is driven primarily by the number of residents who are age 65 years or older, which grew by 5.3% in the 2010-2015 period and is expected to grow by 5.4% over the 2015-2020 period, and continue to grow between 4.8% to 2.5% between 2020 and 2035. It is important to note that residents aged 65 years and older from the Snohomish County Planning Area have an inpatient rehabilitation bed use rate that is about 4.65 times greater than that of residents whose ages range from 15 years old to 64 years of age.

Significant Outmigration of Patients Seeking Rehabilitation Care

Our analysis divided rehab patient days into two planning areas: the Snohomish County Planning Area, and Washington State as a whole minus the Snohomish County Planning Area. The analysis indicates there was 34% out-migration of patient days of persons 15-64 years old, and 27% out-migration of patient days of persons 65 years and older from the Planning Area to hospitals in other planning areas. This is significant as it implies residents do not currently have sufficient access to acute rehabilitation services in Snohomish County Planning Area. Establishing a 40-bed acute rehabilitation unit at a more accessible location can address this issue and allow patients to seek treatment within their Planning Area.

Kindred Has Extensive Experience in Development and Operation of Freestanding Inpatient Rehabilitation Hospitals

Through Kindred's joint ventures with local community partners, access to rehabilitation hospital services has improved for patients across the country, as have patient outcomes. Kindred has accomplished this improved access through its rehabilitation hospital-focused clinical liaisons and admissions teams who assist with the process of identifying and admitting patients who are appropriate for this level of care earlier in their stay at a general acute care hospital in order to place patients in the appropriate setting at the most optimal time to maximize patient outcomes. In addition, there is a strong focus on training clinical staff and developing protocols to better serve a high acuity, more complex and more functionally-impaired population than what is typically seen in inpatient rehabilitation units. These efforts ensure that patients achieve their rehabilitation goals more quickly and regain maximum independence in order to return home or to another community-based setting.

Healthcare Reform Impact on Planning

Health care reform initiatives have placed an increased demand, enhanced focus, and changing regulatory environment for quality post-acute care services. These demands place a premium for service coordination between acute and post-acute providers to improve outcomes, reduce hospital readmissions, reduce costs, and increase patient satisfaction. This joint venture rehabilitation hospital has, as a central goal, the provision of high quality, cost efficient outcomes for acute rehabilitation hospital care to patients in Snohomish County.

The partnership between Providence and Kindred will create a freestanding rehabilitation hospital established on both partners' commitment to providing high quality care. CARF, the Commission on Accreditation of Rehabilitation Facilities, awarded the PRMCE Inpatient Rehabilitation Unit a three-year accreditation in 2016. CARF accreditation means that patients can be confident that this organization has made a commitment to continuously enhance the quality of services and programs and focus on customer satisfaction. Additionally, PRMCE is accredited by the Joint Commission, further demonstrating its commitment to the highest standards in quality care.

PRMCE's partnership with Kindred will further its commitment to quality care. Kindred believes in continuous measurement of patient outcomes as a means to evaluate its clinical programs and quality. Kindred's rehabilitation hospitals are consistently more efficient in improving patients' functioning per day of therapy and more efficient in achieving patient discharges to the community, as compared to the national average. This is especially remarkable because Kindred's rehab patients are more acute and have lower function when they are admitted to Kindred's rehab hospitals, as compared to the national average. Through Kindred's joint ventures, access to inpatient rehabilitation services has improved, as have patient outcomes. Kindred has accomplished this through its inpatient rehabilitation-focused clinical liaisons and admissions teams who assist with the process of admitting patients who are appropriate for this level of care. In addition, there is a strong focus on training clinical staff and developing protocols to better serve a high acuity, more complex and more functionally impaired population than what is typically seen in inpatient rehabilitation units.

As the only acute rehabilitation hospital in the Planning Area, PRMCE and Kindred must adequately plan to meet the current and future need for acute rehabilitation beds. Without this proposed bed expansion, residents of the Planning Area will be compelled to seek care outside of their community, and the ability of PRMCE and Kindred to serve as the only acute rehabilitation hospital could be compromised, especially in a time when need is shown. Approval of this Certificate of Need application will allow PRMCE and Kindred to ensure acute rehabilitation services will be available to meet the growing community need.

I. **APPLICANT DESCRIPTION:**

A. **Legal name(s) of applicant(s).**

The Applicant and operating entity will be Northwest Washington Rehabilitation Hospital, LLC ("NWRH"). NWRH is a joint venture between PRMCE and KND12.

KND12 will be the majority owner of NWRH, with 51% ownership. PRMCE will be the minority owner of NWRH with 49% ownership. PRMCE will contribute up to 19 of its existing rehabilitation beds to the new hospital.

Exhibit 2 includes the Letter of Intent submitted to the Department to establish a 40-bed acute inpatient rehabilitation hospital in Snohomish County.

B. **Address of each applicant.**

The Applicant is Northwest Washington Rehabilitation Hospital, LLC. Per the Articles of Formation, the address of the Applicant is 680 South Fourth Street, Louisville, KY 40202. NWRH requests that all correspondence regarding this application be sent to Providence Regional Medical Center Everett, Administration, 1321 Colby Avenue, Room A2-060, Everett, WA 98201.

C. **If an out of state corporation, submit proof of registration with Secretary of State, Corporations, Trademarks, and Limited Partnerships Division, and a chart showing organizational relationship to any related organizations as defined in Section 405.427 of the Medicare Regulations.**

Northwest Washington Rehabilitation Hospital, LLC is registered in the State of Washington. The registration with the Secretary of State is available in Exhibit 3.

D. **Provide separate listings of each Washington and out-of-state health care facility, including name, address, Medicare provider number, Medicaid provider number, owned and/or managed by each applicant or by a related party, and indicate whether owned or managed. For each out-of-state facility, provide the name, address, telephone number and contact person for the entity responsible for the licensing/survey of each facility.**

Providence Health & Services

Providence Health & Services ("Providence") has facilities located in Alaska, Washington, Montana, Oregon, and California. For the purposes of this CN application, Providence's legal structure has been provided in Exhibit 4. In addition, an organizational chart for the Providence Northwest Washington Service Area is provided in Exhibit 4, as well. Providence Regional Medical Center Everett ("PRMCE") is located in the Providence Northwest Washington Service Area.

On July 1, 2016, Providence and the St. Joseph Health System, a California non-profit corporation, became affiliated. The affiliation created a new "super-parent", Providence St. Joseph Health, a Washington non-profit corporation. It is important to note that Providence remains a viable corporation, as well as any and all subsidiaries and D/B/As that fall under that corporate umbrella. This new affiliation did not change the name or corporate structure of Providence, Providence Health & Services – Washington, or

Providence Regional Medical Center Everett. Please see Exhibit 5 for a listing of the facilities owned, operated, and managed by Providence Health & Services.

Table 1. PRMCE Medicare and Medicaid Provider Numbers

	Medicare Provider Number	Medicaid Provider Number
Acute Care	50-0014	2001252
Rehabilitation	50-T014	2001268

Kindred Healthcare, LLC

Kindred Healthcare, LLC (“Kindred”) is a national provider of post-acute care services. Please see Exhibit 5 for a listing of the hospitals, long-term care facilities and rehabilitation agencies owned and operated by Kindred.

Kindred Development 12, LLC (“KND12”) is a subsidiary of Kindred. KND12 does not own or operate any other facilities.

Northwest Washington Rehabilitation Hospital, LLC

Northwest Washington Rehabilitation Hospital, LLC (“NWRH”) is a joint venture between PRMCE and KND12. Exhibit 4 includes an organizational chart for NWRH, which demonstrates the joint venture relationship of PRMCE and KND12.

E. Facility licensure/accreditation status.

NWRH will receive a hospital acute care license in accordance with RCW 70.41. All beds will operate as Level I rehabilitation beds. NWRH will also seek accreditation from The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities (CARF). The existing 19-bed Level II acute rehabilitation unit has also received accreditation from The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities (CARF).

F. Is the applicant reimbursed, or plans to be reimbursed, for services under Titles V, XVIII, and XIX of the Social Security Act?

NWRH intends to be reimbursed for services provided by both Titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act.

G. Describe the history of each applicant with respect to criminal convictions related to ownership/operation of health care facility. License revocations and other sanctions described in WAC 248-19-390(5)(a). If there have been such convictions or sanctions, so state.

There have been no such convictions or sanctions. Neither Northwest Washington Rehabilitation Hospital, nor its members, Providence Health & Services-Washington and Kindred Development 12, L.L.C., has any history as described in WAC 246-310-230 (5)(a) (now codified as WAC 246-310-230(5)(a).) Patient care at Northwest Washington Rehabilitation Hospital will be provided in conformance with all applicable federal and state requirements.

II. FACILITY DESCRIPTION

A. Name and address of the proposed/existing facility.

The proposed address for Northwest Washington Rehabilitation Hospital is 12911 Beverly Park Road, Lynnwood, WA 98087.

B. Name and address of owning entity at completion of project (unless same as applicant)

The legal name of the owning entity at completion is Northwest Washington Rehabilitation Hospital, LLC, the same as the Applicant.

C. Provide the following information about the owning entity (unless same as applicant)

Not applicable. Northwest Washington Rehabilitation Hospital, LLC is registered in Washington.

- 1. If an out of state corporation, submit proof of registration with Secretary of State, Corporations, Trademarks, and Limited Partnerships Division, and a chart showing organizational relationship to any related organizations as defined in Section 405.427 of the Medicare Regulations.**

Not applicable.

- 2. If an out of state partnership, submit proof of registration with Secretary of State, Corporations, Trademarks, and Limited Partnerships Division, and a chart showing organizational relationship to any related organizations as defined in Section 405.427 of the Medicare Regulations.**

Not applicable

D. Name and address of operating entity (unless same as applicant)

The operating entity is the same as the Applicant.

E. Geographic identity of primary service area

The proposed service area for this project is Snohomish County. Please see Exhibit 6 for the Snohomish County Planning Area definition and map.

F. Peer group

This question is no longer applicable.

G. List physician specialties represented on active medical staff and indicate number of active staff per specialty

The proposed facility is not yet operational. Therefore, there is no current active medical staff roster that is specific to NWRH. However, PRMCE currently has 15 Physical Medicine and Rehabilitation physicians on its medical staff. While the medical staff at the

new facility will be finalized after CN approval, NWRH anticipates that many of the current physicians will join the medical staff at the new rehabilitation hospital.

H. List all other generally similar providers currently operating in the primary service area

Providence Regional Medical Center Everett is the only provider of acute inpatient rehabilitation services in Snohomish County.

Following CN approval and the opening of the new NWRH hospital, the 19 acute inpatient rehabilitation beds at PRMCE will be relocated to the new inpatient rehabilitation hospital, which also will be located within Snohomish County.

I. For existing hospitals, provide:

- 1. inpatient days per year for the past five years**
- 2. total licensed capacity at present**
- 3. average number of set-up beds in the last twelve months**

NWRH does not currently exist and does not have historical utilization to provide. Table 2 provides historical utilization for the rehabilitation unit at PRMCE.

Table 2. Historical Occupancy at PRMCE Rehabilitation Unit

	2013	2014	2015	2016	2017	2018
Patient Days	5,704	5,427	5,339	5,084	4,587	4,546
Average Daily Census	15.6	14.9	14.6	13.9	12.6	12.5
Bed Supply	19	19	19	19	19	19
Occupancy	82%	78%	77%	73%	66%	66%

Source: CHARS 2013 - 2017; PRMCE 2018

While the rehabilitation unit at PRMCE has experienced a small decline in Average Daily Census of three patients per day during the past five years, this was primarily a result of leadership transitions, a change in payer contracts, and lack of bed availability while the facility was undergoing patient room and facility renovation. First, while the leadership of the unit is now stable, in past years the unit experienced a period of staffing transition at the Program Director and Clinical Liaison levels that affected the occupancy of the unit and the ability to transition patients into the rehab unit in a timely manner. The unit now has these key positions filled and is strengthening its foundation to support utilization growth. Second, the unit was absent a key payer contract, which also affected patient admissions. This contract is now in place and expected to remain so in the future. Lastly, the unit underwent renovations which required some patient rooms to be unavailable for patient care. These renovations are complete, and the unit is now at full capacity to care for patients.

The freestanding rehabilitation hospital will serve as a regional destination for high quality inpatient rehabilitation care for patients throughout Snohomish County. NWRH will rely on both PRMCE's and Kindred's reputation as high quality providers to

communicate the benefits of inpatient rehabilitation care. It also will rely on PRMCE's reputation as an employer of choice in the area and Kindred's recruitment strategies that have proven successful throughout its portfolio of rehabilitation hospitals, including at CHI Franciscan Rehabilitation Hospital which opened in 2018, to recruit all necessary staff for successful operations.

Through Kindred's joint ventures with local community partners, access to rehabilitation hospital services has improved for patients across the country, as have patient outcomes. Kindred has accomplished this improved access through its rehabilitation hospital-focused clinical liaisons and admissions teams who assist with the process of identifying and admitting patients who are appropriate for this level of care earlier in their stay at a general acute care hospital in order to place patients in the appropriate setting at the most optimal time to maximize patient outcomes. In addition, there is a strong focus on training clinical staff and developing protocols to better serve a high acuity, more complex and more functionally-impaired population than what is typically seen in inpatient rehabilitation units. These efforts ensure that patients achieve their rehabilitation goals more quickly and regain maximum independence in order to return home or to another community-based setting. Through implementing these strategies at all of its rehabilitation hospitals, Kindred has experienced significant increases in inpatient rehabilitation utilization at its joint venture rehabilitation hospitals with partners that had previously operated inpatient rehabilitation units.

- J. If this project involves construction of 12,000 square feet or more, or construction associated with parking for forty or more vehicles, submit a copy of either an Environmental Impact Statement or a Declaration of non-Significance from the appropriate governmental authority.**

NWRH has consulted with the County of Snohomish regarding the process for obtaining the appropriate land use permits. NWRH must obtain a Conditional Use Permit since the proposed site is in an Airport Compatibility Area. A State Environmental Policy Act ("SEPA") determination is part of this process, and both applications are in process. NWRH understands the Department of Health will issue an "intent to issue" a certificate of need, rather than the actual certificate of need until this requirement is met. A copy of the documentation associated with the applicable reviews will be provided to the Department prior to opening the new facility.

III. PROJECT DESCRIPTION:

- A. Describe the proposed project. This description should include discussion of any proposed conversion or renovation of existing space to other purposes, as well as the construction of new facility space. Also specify any unique services being proposed.**

This project requests CN approval for the establishment of a new, freestanding 40-bed acute rehabilitation hospital in Snohomish County. The hospital will provide intensive Level I comprehensive, state-of-the-art acute rehabilitation services for patients with impairments resulting from a traumatic medical situation (e.g., stroke, serious spinal cord and brain injury, neurologic illness, major multiple traumas, orthopedic conditions with complex or profound impairments).

At the time that NWRH receives its license and begins operation, PRMCE will close its existing 19-bed Level II acute rehabilitation unit and will submit appropriate documentation to the Department of Health to remove those 19 rehabilitation beds from the PRMCE hospital license or file a separate CN application to change the designation of the beds.

- B. Type of project (indicate all that apply):**

1. **New Facility or Service**
2. **Total replacement of Existing Facility**
3. **Renovation or Modernization**
4. **Mandatory Correction of Fire and Life/Safety Deficiencies**
5. **Substantial Change in Services**
6. **Expansion/Reduction of Facility**
7. **Pre-Development Expenditure in Excess of Minimum**

- C. If the proposed project involves the purchasing of an existing service, identify the present owner(s) of that service.**

The question is not applicable since this project does not involve the purchase of an existing service.

- D. Describe any change in licensed and/or set-up bed capacity by unit/service which are part of this project.**

At the time that NWRH receives its license and begins operation, PRMCE will close its existing 19-bed Level II acute rehabilitation unit and will submit appropriate documentation to the Department of Health to remove those 19 rehabilitation beds from the PRMCE hospital license or file a separate CN application to change the designation of the beds.

E. Total estimated capital expenditures.

The total capital expenditures for this project are \$3,000,000.

F. Total estimated facility-wide operating expenses for the first and second years of operation (separately shown)

Table 3. Projected Operating Expenses

Year	Operating Expenses
July – December 2021	\$5,809,805
2022	\$11,530,772
2023	\$11,655,117

G. General description of types of patients to be served by the project. Describe the extent of any planned limitations to the services offered, either during the initial years of the project or on a permanent basis.

Inpatient rehabilitation hospitals offer full-time rehabilitation, interdisciplinary care management and 24-hour, physician-supported medical care. Rehabilitation teams are driven to help each patient get stronger and more independent, recover more rapidly, and return home.

The project is intended to serve patients from the Snohomish County service area who require inpatient rehabilitation services to regain functional status. Each patient is treated with a specialized intense rehabilitation plan that is customized based on each individual's existing abilities, tolerance for therapy and desired outcomes to prepare them to return home. Each patient receives 24-hour nursing care and at least three hours of therapy per day to support them on the path to recovery. As part of each personalized treatment plan, patients will work with a comprehensive team of doctors, nurses and therapists trained in the field of Physical Medicine and Rehabilitation. This specialized team evaluates and develops a personalized treatment plan designed to help each individual recover and develop the skills needed to return home or to live as independently as possible.

The vast majority of the patients identified with medical conditions and functional impairments that make them eligible for inpatient rehabilitation often require a stay in a local acute care hospital for one of the following conditions prior to admission to the proposed rehabilitation hospital: brain injury, spinal cord injury, neurological conditions (including stroke), major multiple trauma, complex orthopedic conditions or profound impairments, lower extremity amputation, or cardiac, pulmonary and/or other major health incidents that require advanced rehabilitation to regain functional status and return to their prior lives. It is anticipated that the majority of patients treated in the proposed hospital will be age 65+; however, the proposed hospital also is expected to treat a significant number of patients younger than 65 years old who suffer from traumatic incidents (i.e., spinal cord and brain injury, other complex neurologic conditions, and accidents with or without traumatic injury).

The project will not result in any limitations to the proposed services offered, either during the initial years of the project or on a permanent basis.

- H. Project utilization of service(s) for the first three years of operation following project completion (shown separately). This should be expressed in appropriate workload units of measure (for hospitals, appropriate workload units of measure and ACMVUs as required in the Accounting for Reporting Manual for Hospitals of the State Hospital Commission should be used). RVU measures should also be expressed in procedure units.**

**Table 4. Northwest Washington Rehabilitation Hospital
Projected Utilization**

	July-December 2021	2022	2023	2024
Patient Discharges	215	474	489	504
Patient Days	2,242	5,747	5,929	6,117
Average Daily Census	12.2	15.7	16.2	16.7
# of Beds	40	40	40	40
Occupancy	30.5%	39.4%	40.6%	41.8%

Source: Applicant

During the initial months of operation, NWRH will focus its efforts on outreach to the medical community and referral sources for inpatient admissions, establish payor contracts, and undergo the process to obtain Joint Commission accreditation and CMS certification as an Inpatient Rehabilitation Facility. Once much of the initial startup processes are complete, NWRH expects to experience increased utilization starting with the first full calendar year of operation and beyond.

- I. If applicable, include a copy of the functional program**

Not applicable.

- J. Existing sources of patient revenue (Medicare, etc.) with percentage revenue from each source**

This facility is not yet in operation and does not have existing sources of patient revenue. As such, this question is not applicable.

- K. Source(s) of financing**

Kindred will provide \$3,000,000 in funds to NWRH for purchase of equipment for the rehabilitation hospital. A letter from Kindred attesting to its funding of this project is provided in Exhibit 7. The Kindred audited financial statements in Appendix 2 document its resources to provide these funds for this project.

Kindred Healthcare Operating, LLC has entered into a purchase and sale agreement with Tree Owl Properties, LLC (property owner) for the site. Kindred Healthcare Operating, LLC will sell the property to a third-party developer, and the developer will

construct the building and lease the land and building to NWRH. The signed purchase and sale agreement and a letter describing this process are included in Exhibit 8. In addition, a letter of intent and term sheet from a potential developer is available in Exhibit 9. This letter of intent is provided for estimation purposes. The Board of Managers for NWRH will make a final decision on a developer after a Request for Proposal process and will agree to a maximum price for development and construction of the proposed rehabilitation hospital through an agreement with the third-party developer. This decision will not occur until after CN approval.

L. Equipment proposed:

1. Description of new and replacement equipment proposed.

Please see Exhibit 10 for a proposed equipment list. NWRH plans to purchase all new equipment in order to meet the care and rehabilitation therapy needs of its patients. A discussion of some of the equipment planned for this hospital is available in the response to N. below.

2. Description of equipment to be replaced, including cost of equipment and salvage value, if any, or disposal or use of the equipment to be replaced.

This is a new facility, and NWRH plans to purchase all new equipment for the rehabilitation hospital. As such, no equipment will be replaced.

M. Single line drawings to scale of current locations which identify current departments and services.

This question is not applicable, since no facility currently exists.

N. Single line drawings to scale of proposed locations which identify current departments and services.

Single line drawings of the proposed inpatient rehabilitation hospital are available in Exhibit 11.

The hospital is designed to create an exceptional healing environment for rehabilitation patients. A state-of-the-art facility with a designated patient room area for stroke and traumatic brain injury patients enables clinical staff to more effectively care for the unique medically-complex needs of these special patient populations. The hospital will have a large therapy area, with a full spectrum of equipment for physical and occupational therapy. It also includes a car for patients to practice entering and exiting a vehicle, since this is an important part of regaining independence.

The therapy area also includes an apartment where patients and families can stay together prior to discharge so the patient can practice skills such as cooking, bathing, laundry, and transferring in and out of a regular bed. The apartment also includes other common household items and appliances the patient can practice using in order to build strength, skills and confidence to accomplish important tasks prior to discharge.

The facility design also accommodates the use of state-of-the-art technology. The therapy gym will have a dedicated space for the use of an Ekso Bionics EksoGT[®], the first FDA-cleared exoskeleton for stroke and spinal cord injury rehabilitation. This provides assistance to patients relearning to walk and building the strength to walk independently. This is new technology that has delivered promising results.

The neuro and brain injury unit is specifically designed for patients with some type of acquired brain injury or related symptoms including stroke, multiple sclerosis, and Parkinson's. This unit is secured for patient safety, and it has a dedicated therapy gym and dining area customized to meet the needs of this specific patient population that often is sensitive to light, color, noise and other environmental stimuli.

This facility design has been implemented at several Kindred Rehabilitation Hospitals throughout the country with significant success in enhancing patient outcomes and improving their quality of life and opportunity to return home after discharge.

O. Geographic location of site of proposed project, if other than hospital campus.

1. Indicate number of acres in the site.

4.4 acres

2. Indicate number of acres in any alternate site, if applicable.

No alternate site exists for this project.

3. Indicate if the primary or alternate site has been acquired, if applicable.

A purchase agreement for the site is available in Exhibit 8.

4. Address of site

12911 Beverly Park Road, Lynnwood, WA 98087

Address of alternate site:

No alternate site exists

5. If the primary site or alternate site has not been acquired, explain how you will select and acquire a site for the project.

Kindred Healthcare Operating, LLC has entered into a purchase and sale agreement with Tree Owl Properties, LLC (property owner) for the site. Kindred Healthcare Operating, LLC will sell the property to a third-party developer, and the developer will construct the building and lease the land and building to NWRH. The signed purchase and sale agreement and a letter describing this process are included in Exhibit 8.

- 6. Describe any of the following which would currently restrict usage of the proposed site and/or alternate site for the proposed project:**

(a) mortgages; (b) liens; (c) assessments; (d) mineral or mining rights; (e) restrictive clauses in the instrument of conveyance; (f) easements and right of ways; (g) building restrictions; (h) water and sewage access (i) probability of flooding; (j) special use restrictions; (k) existence of access roads; (l) access to power and/or electricity sources; (m) shoreline management/environmental impact; (n) others, please explain.

NWRH has consulted with the County of Snohomish regarding the process for obtaining the appropriate land use permits. The selected site is currently zoned PCB (Planned Community Business), which allows for the proposed inpatient rehabilitation hospital. Documentation of proper zoning is available in Exhibit 12. In addition to proper zoning, NWRH must obtain a Conditional Use Permit since the proposed site is in an Airport Compatibility Area. A SEPA determination is part of this process, and both applications are in process. NWRH understands that the Department will issue an "intent to issue" certificate of need, rather than the actual certificate of need until this requirement is met.

- 7. Provide documentation that the proposed site may be used for the proposed project. Include a letter from any appropriate municipal authority indicating that the site for the proposed project is properly zoned for the anticipated use and scope of the project or a written explanation of why the proposed project is exempt.**

Documentation of appropriate zoning is available in Exhibit 12.

- 8. Provide documentation that the applicant has sufficient interest in the site of facility proposed. Sufficient interest shall mean one of the following:**

- a. Clear legal title to the proposed site; or**
- b. A lease for at least five years with option to renew for not less than a total of twenty years in the case of a hospital, psychiatric hospital, or rehabilitation facilities; or**
- c. A lease for at least one year with option to renew for not less than a total of five years in the case of freestanding kidney facilities, hospices, or home health agencies; or**
- d. A legally enforceable agreement to give such title or such lease in the event that a Certificate of need is issued for the proposed project.**

Kindred Healthcare Operating, LLC has entered into a purchase and sale agreement with Tree Owl Properties, LLC (property owner) for the site. Kindred Healthcare Operating, LLC will sell the property to a third-party developer, and the developer will construct the building and lease the land and building to NWRH. The signed purchase and sale agreement and a letter describing this process are included in Exhibit 8.

P. Space Requirements

1. Existing gross square feet.

Not applicable. The facility does not currently exist.

2. Total gross square footage for proposed new addition and existing facility or proposed gross square footage for the proposed entirely new facility.

The gross square footage (“GSF”) for the proposed facility is 53,004 GSF.

3. Provide a matrix showing net square feet for all involved services and departments before and after project completion.

Table 5. Square Footage by Department

Area	Gross Square Feet	Net Square Feet
First Floor		
- Patient Rooms	8,546	7,263
- Dining	1,768	1,729
- Kitchen	1,971	1,748
- Office	1,364	1,119
- Treatment (Therapy, Support Areas, Chapel)	7,528	7,041
- Mechanical/Storage	3,082	2,828
- Circulation, Common Areas (Lobby, Public Restrooms)	8,762	8,598
Total First Floor	33,021	30,326
Second Floor		
- Patient Rooms	6,246	5,317
- Dining	830	761
- Office	3,165	2,783
- Treatment (Therapy, Support Areas, Chapel)	3,997	3,570
- Mechanical/Storage	352	313
- Circulation, Common Areas (Lobby, Public Restrooms)	5,693	5,419
Total Second Floor	19,983	18,363
Total First and Second Floor	53,004	48,689

4. Do the above responses include any shelled-in areas?

Yes _____ No X

Q. Proposed Timetables for Project Implementation

The Certificate of Need Program will use the following timetable in monitoring the applicant's conformance with the issued Certificate of Need. Failure to meet the specified timetable may be grounds for revocation of a Certificate of Need. (WAC 246-310-500)

1. Financing, if project is to be externally funded.

Not applicable.

- a. **Date for obtaining construction financing. (Month/Year)**
Not applicable.
- b. **Date for obtaining permanent financing. (Month/Year)**
Not applicable.
- c. **Date for obtaining funds necessary to undertake the project. (Month/Year)**
Not applicable.

2. Design

- a. **Date for completion and submittal to Consultation and Construction Review Section of preliminary drawings. (Month/Year)**
August 2019
- b. **Date for completion and submittal to Consultation and Construction Review Section of final drawings and specifications. (Month/Year)**
November 2019

3. Construction

- a. **Date for construction contract award. (Month/Year)**
November 2019 or upon Certificate of Need approval
- b. **Date for 25 percent completion of construction (25% of the dollar value of the contact in place). (Month/Year)**
July 2020
- c. **Date for 50 percent completion of construction. (Month/Year)**
November 2020
- d. **Date for 75 percent completion of construction. (Month/Year)**
February 2021
- e. **Date for completion of construction. (Month/Year)**
May 2021

f. Date for obtaining license approval. (Month/Year)

July 2021

g. Date for occupancy/offering of service. (Month/Year)

July 2021

R. As the applicant(s) for this project, describe your experience and expertise in the planning, developing, financing, and construction of this type of project.

About Providence Health & Services – Washington

Providence has provided patient care since 1856. Providence continues a tradition of caring that the Sisters of Providence began more than 160 years ago. The cornerstone of its mission is to provide compassionate care that is accessible for all – especially those who are poor and vulnerable. In addition, in its undertakings, Providence focuses on a core vision of “Health for a Better World.” PRMCE is a 530 licensed bed hospital, which provides both inpatient and outpatient services to patients from Snohomish and surrounding counties.

Providence has significant experience and expertise in planning, developing, financing and implementing projects similar to the requested project. For example, Providence in Snohomish County has successfully completed construction of several large projects, including a 12-story medical tower on the Colby Campus and a 42,000-square-foot ambulatory care center in Monroe. PRMCE has a seasoned construction department that provides a high level of expertise in health care construction.

About Kindred Healthcare

Kindred Healthcare, LLC is a health care services company based in Louisville, Kentucky. Kindred, through its subsidiaries, has approximately 35,700 employees providing health care services in 1,789 locations in 45 states, including 74 long-term acute care hospitals, 22 inpatient rehabilitation hospitals (like the hospital proposed in this application), 11 sub-acute units, 96 managed inpatient rehabilitation units (hospital-based) and has contractual partnerships with 1,586 hospitals and long term care facilities for the provision and management of rehabilitation services to patients. Ranked as one of Fortune magazine’s Most Admired Healthcare Companies for nine years, Kindred’s mission is to help our patients reach their highest potential for health and healing with intensive medical and rehabilitative care through a compassionate patient experience. More information on Kindred is available in its 2018 Quality Report available in Exhibit 13.

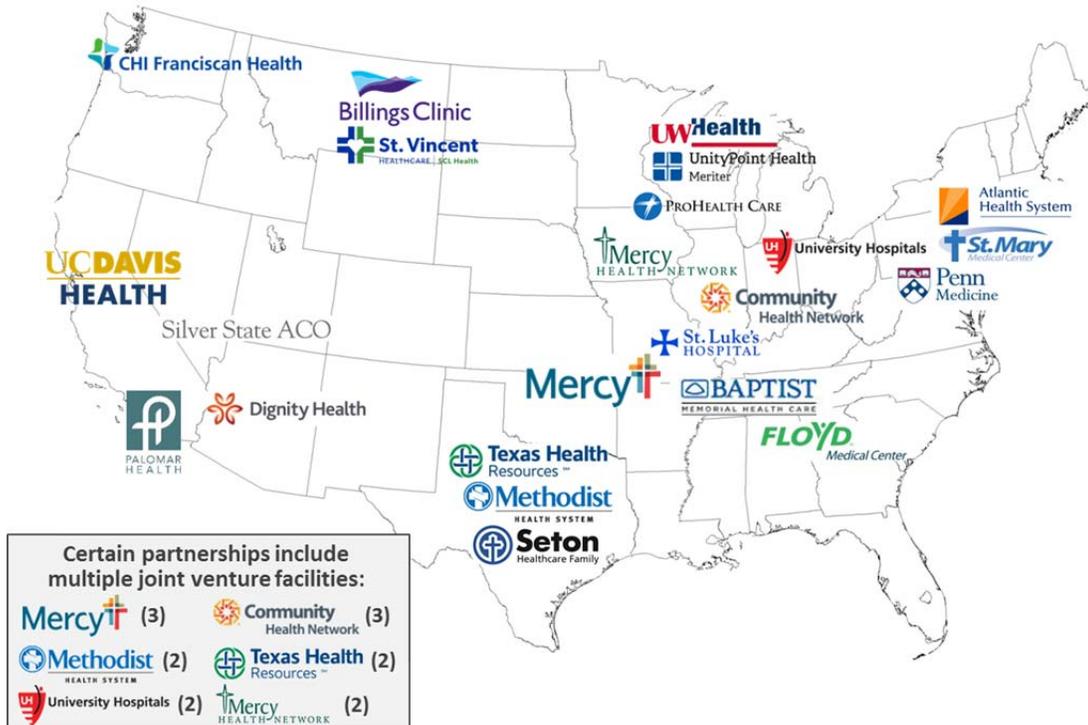
Kindred operates a wide range of freestanding inpatient rehabilitation hospital joint ventures, having developed multiple freestanding rehabilitation hospitals with not-for-profit local community partners across the country.

Kindred leads the development and implementation of these hospitals, from site selection and real estate transactions to project design and collaboration with developers for building construction of projects that are consistently built on time and on budget. Its

extensive experience with the implementation and opening of hospitals involves such key functions as equipment budgeting and installation, staffing and licensure, certification and accreditation.

A map of these joint venture partnerships follows:

Figure 1. Kindred's Joint Venture Experience



S. Describe the relationship of this project to the applicant(s)' long-range plan and long-range financial plan (if any).

This project is part of PRMCE's and KND12's long-range strategic and financial plans for meeting the needs of patients seeking inpatient rehabilitation services in Snohomish County. The proposed inpatient acute rehabilitation hospital will further the shared mission both organizations, providing care that is focused on the Triple Aim: to be the preferred choice of consumers for patient experience, known for clinical quality outcomes, and operated in the most cost efficient manner possible.

PRMCE and KND12 are collaborating to create an environment of exceptional clinical care for rehabilitation patients that is built on the strengths of both organizations. Kindred is the nation's largest provider of integrated care for people with post-acute and chronic care needs. It partners with some of the nation's premier hospitals and health systems, through joint ventures and contract management relationships, to make recovery possible for patients in local markets every day. Kindred's experience operating inpatient rehabilitation hospitals will complement the highly regarded acute care PRMCE currently provides in Snohomish County, resulting in a partnership that will drive

efficiencies and clinical integration and deliver the best in patient care. This partnership will also provide Snohomish County patients with access to the highest quality inpatient rehabilitation services.

Health Care Reform Impact on Planning

Health care reform initiatives have placed an increased demand, enhanced focus, and changing regulatory environment for quality post-acute care services. These place a premium for service coordination between acute and post-acute providers to improve outcomes, reduce hospital readmissions, reduce costs, and increase patient satisfaction. This joint venture rehabilitation hospital has, as a central goal, the provision of high quality, cost efficient outcomes for acute rehabilitation hospital care to patients in Snohomish County.

Kindred's experience has shown that care in a freestanding hospital setting can be provided more efficiently than in hospital-based units. This is supported by research submitted to CMS by the Medicare Payment Advisory Commission³, which states that, "freestanding IRFs had a median standardized cost per discharge that was 27 percent lower than that of hospital-based IRFs (\$12,069 vs. \$16,645, respectively)."

³ Medicare Payment Advisory Commission (MedPAC). Report to the Congress: Medicare Payment Policy, "Chapter 10: Inpatient Rehabilitation Facility Services". p.270.
http://medpac.gov/docs/default-source/reports/mar19_medpac_entirereport_sec.pdf?sfvrsn=0

IV. PROJECT RATIONALE:

A. NEED (WAC 246-310-210)

1. Identify and analyze the unmet health services needs and/or other problems to which this project is directed.

Overview

Providence Regional Medical Center Everett has served the health care needs of Snohomish County residents and other regional patients for more than 110 years. Throughout its history in Everett, PRMCE has continued to plan for the future needs of Snohomish County and the surrounding regional area.

Given several important factors, there is current and future need for additional inpatient rehabilitation capacity in the Planning Area. The inpatient rehabilitation bed capacity must be increased so that Snohomish County and other area residents will have access to high quality inpatient rehabilitation care. Key factors include:

- (1) Occupancy rate at PRMCE (Table 6, below);
- (2) Growth in Planning Area population (Table 7);
- (3) The demonstrated need for rehabilitation beds when a bed need model is applied to the Planning Area (Table 8, below, and Exhibit 14).

These factors are described below. In summary, they demonstrate need for additional inpatient rehabilitation beds in the Snohomish County Planning Area. The proposed project, NWRH, would fully meet the future needs of Planning Area residents and the surrounding region by requesting approval of a 40-bed facility, which would include a net increase of 21 additional inpatient rehabilitation beds, given the project also includes the planned closure of the 19-bed unit at PRMCE.

Occupancy Statistics

During the past five years, PRMCE's inpatient rehabilitation unit has been operating well above the occupancy standard of 55% established by the Department for specific services (See Table 6).⁴ Further, while the recent CY2017 ADC (average daily census) may not translate into a high average occupancy for 19 dedicated inpatient rehabilitation beds, it is important to note that "averages" mask variability in census. When there are peaks in census, this can cause overcapacity within the unit, thereby forcing rehabilitation patients to seek care at other facilities, most frequently with Seattle providers at distances that often create a burden for family members.

⁴ See p. C-37, Criterion 11. "Occupancy Standards for Use in Forecasting Specific Services," Volume II, Washington State Health Plan, 1987.

Table 6. Historical Occupancy at PRMCE Rehabilitation Unit

	2013	2014	2015	2016	2017	2018
Patient Days	5,704	5,427	5,339	5,084	4,587	4,546
Average Daily Census	15.6	14.9	14.6	13.9	12.6	12.5
Bed Supply	19	19	19	19	19	19
Occupancy	82%	78%	77%	73%	66%	66%

Source: CHARS 2013 - 2017; PRMCE 2018

While the rehabilitation unit at PRMCE has experienced a small decline in Average Daily Census of three patients during the past five years, this was primarily a result of leadership transition, a change in payer contracts, and lack of bed availability while the facility was undergoing patient room and facility renovation. First, while the leadership of the unit is now stable, in past years the unit experienced a period of staffing transition at the Program Director and Clinical Liaison levels that affected the occupancy of the unit and the ability to transition patients into the rehab unit in a timely manner. The unit now has these key positions filled and is strengthening its foundation to support utilization growth. Second, the unit was absent a key payer contract, which also affected patient admissions. This contract is now in place and expected to remain so in the future. Lastly, the unit underwent renovations which required some patient rooms to be unavailable for patient care. These renovations are complete and the unit is now at full capacity to care for patients.

The proposed NWRH freestanding rehabilitation hospital will serve as a regional destination for high quality inpatient rehabilitation care for patients throughout Snohomish County. NWRH will rely on both PRMCE's and Kindred's reputation as high quality providers to communicate the benefits of inpatient rehabilitation care. It also will rely on PRMCE's reputation as an employer of choice in the area and Kindred's recruitment strategies that have proven successful throughout its portfolio of rehabilitation hospitals, including at CHI Franciscan Rehabilitation Hospital, which opened in 2018.

Population Statistics

From 2010-2015, the Snohomish County Planning Area adult population (ages 15 and older) grew 1.4% annually, and in 2018, there were more than 652,364 residents 15 years of age and older living in the Planning Area (Table 7).

The growth is driven primarily by growth in residents aged 65 and older. Specifically, the population aged 65 and older grew 5.3% per year from 2010 to 2015, and is forecasted to grow 5.4% per year over 2015-2020, 4.8% per year from 2020-2025, 3.7% per year from 2025-2030, and finally 2.5% per year from 2030-2035.

Older residents demand greater levels of inpatient rehabilitation care, and the much higher annual growth in the 65+ age group signifies increasing demand for inpatient rehabilitation care in the Planning Area. As discussed further below, residents aged 65 years and older from the Snohomish County Planning Area

have an inpatient rehabilitation bed use rate that is about 4.65 times greater than that of residents whose ages range from 15 years old to 64 years of age.

Table 7. Snohomish County Planning Area. Historic and Forecast Resident (Ages 15+) Population Figures, 2010-2035

	2010	2015	2020	2025	2030	2035	Average Annual Growth Rates				
							2010-2015	2015-2020	2020-2025	2025-2030	2030-2035
15 to 64 Years Old	496,644	517,258	554,377	572,015	589,098	612,480	0.8%	1.4%	0.6%	0.6%	0.8%
65+ Years Old	73,544	95,788	125,219	159,013	191,668	216,909	5.3%	5.4%	4.8%	3.7%	2.5%
Total Population, Ages 15+	570,188	613,046	679,596	731,028	780,766	829,389	1.4%	2.1%	1.5%	1.3%	1.2%

Source: OFM Small Area Demographic Estimates (SADE) 2000-2017; OFM Medium Series Estimates, 2010-2040 (2017 release)

Planning Area Forecast Rehabilitation Bed Need

As shown in Table 8 below, there is a current (2019) need for 7.0 rehabilitation beds in the Planning Area, with need growing to 18.5 beds in 2032. The need methodology for the Snohomish County Planning Area is explained below and in Exhibit 14.

Table 8. Snohomish County Planning Area Rehabilitation Bed Need Forecast, Inpatients 15 years of Age and Older, 2017-2032.

	2017	2018	2019	2020	2021	2022	2023	2024
Snohomish County Planning Area								7-Years
Population 15-64 (1)	530,983	538,342	545,804	554,377	557,850	561,344	564,860	568,399
15-64 Use Rate (2)	5.77	5.82	5.88	5.93	5.98	6.04	6.09	6.15
Population 65+ (1)	108,222	114,021	120,131	125,219	131,203	137,472	144,041	150,924
65+ Use Rate (2)	26.83	26.89	26.94	27.00	27.05	27.10	27.16	27.21
Total Population	639,205	652,364	665,935	679,596	689,052	698,816	708,901	719,322
Total Snohomish County Planning Area Resident Days	5,967	6,200	6,444	6,668	6,887	7,115	7,353	7,600
Total Days in Snohomish County Planning Area Hospitals	4,862	5,041	5,228	5,400	5,571	5,747	5,929	6,117
Available Beds (3)								
<i>Providence Regional Medical Center Everett</i>	19	19	19	19	19	19	19	19
TOTAL	19	19						
Wtd Occ Std	55.00%	55.00%	55.00%	55.00%	55.00%	55.00%	55.00%	55.00%
Gross Bed Need (TPD/365/Occupancy)-- Demand	24.2	25.1	26.0	26.9	27.7	28.6	29.5	30.5
Bed Supply	19.0	19.0	19.0	19.0	19.0	19.0	19.0	19.0
Net Bed Need/Surplus (Demand - Supply)	5.2	6.1	7.0	7.9	8.7	9.6	10.5	11.5

(1) Population Sources: OFM SADE 2008-2017; OFM 2017 Medium Series Projections (January 2018 Release); OFM Forecast of the State Population by Age and Sex (2017 Release)

(2) 2017 Resident (Age 15 and older) Use Rate Data Source: CHARS 2017 and 2015 Oregon Hospital Discharge Data. See Steps 5 & 6. Future use rates adjusted per slope trends from Step 4.

(3) Total patient days adjusted to reflect referral patterns into and out of Planning Area to other WA State planning areas. See Steps 5 & 6.

Table 8 (continued)

	2025	2026	2027	2028	2029	2030	2031	2032
Snohomish County Planning Area								15 years
Population 15-64 (1)	572,015	575,382	578,768	582,174	585,601	589,098	593,684	598,306
15-64 Use Rate (2)	6.20	6.25	6.31	6.36	6.42	6.47	6.52	6.58
Population 65+ (1)	159,013	164,953	171,115	177,507	184,138	191,668	196,410	201,270
65+ Use Rate (2)	27.26	27.32	27.37	27.43	27.48	27.53	27.59	27.64
Total Population	731,028	740,335	749,883	759,681	769,739	780,766	790,094	799,576
Total Snohomish County Planning Area Resident Days	7,882	8,105	8,335	8,572	8,817	9,089	9,291	9,499
Total Days in Snohomish County Planning Area Hospitals	6,329	6,499	6,673	6,851	7,033	7,233	7,380	7,530
Available Beds (3)								
<i>Providence Regional Medical Center Everett</i>	19	19	19	19	19	19	19	19
TOTAL	19							
Wtd Occ Std	55.00%	55.00%	55.00%	55.00%	55.00%	55.00%	55.00%	55.00%
Gross Bed Need (TPD/365/Occupancy)-- Demand	31.5	32.4	33.2	34.1	35.0	36.0	36.8	37.5
Bed Supply	19.0	19.0	19.0	19.0	19.0	19.0	19.0	19.0
Net Bed Need/Surplus (Demand - Supply)	12.5	13.4	14.2	15.1	16.0	17.0	17.8	18.5

(1) Population Sources: OFM SADE 2008-2017; OFM 2017 Medium Series Projections (January 2018 Release); OFM Forecast of the State Population by Age and Sex (2017 Release)

(2) 2017 Resident (Age 15 and older) Use Rate Data Source: CHARS 2017 and 2015 Oregon Hospital Discharge Data. See Steps 5 & 6. Future use rates adjusted per slope trends from Step 4.

(3) Total patient days adjusted to reflect referral patterns into and out of Planning Area to other WA State planning areas. See Steps 5 & 6.

Rehab Bed Need Methodology

In the case of acute care bed requests, the methodology used to estimate the need for future acute care beds is defined in the hospital bed need forecasting methodology in the Washington State Health Plan (“SHP”)⁵. Although the SHP was sunset in 1989, the Department of Health has concluded that this methodology remains a reliable tool for predicting the baseline need for acute care beds, thus still uses this methodology consistently on all CN decisions related to acute care bed requests.

Since there is no rehabilitation-specific methodology defined in the SHP or by the Department, the acute care forecast model has been used, modified to reflect adult rehab days and use rates only. The methodology defines how data sets of total patient days and population are created and how they are used

⁵ Washington State Health Plan, Vol. II, “Performance Standards for Health Facilities and Services,” May 12, 1987. Pages C-40 through C-44 explain the different “steps” required by the bed need methodology.

mathematically to create bed need forecasts for a defined planning area--in this case, the Snohomish County Planning Area. The methodology for each of the steps is summarized below. The actual bed need projections are presented above in Table 8. All calculations for Steps 1-10 are presented in Exhibit 14. The methodology uses population and total patient day statistics for the state, the Health Service Area ("HSA")⁶, and the Snohomish County Planning Area.

The bed need model adopted in this application is consistent with prior Department evaluations of dedicated rehabilitation bed expansion requests, with four revisions:

- (1) Historically, the Department has relied upon DRGs 945 and 946 as the definition for rehabilitation utilization. However, due to the conversion from ICD-9 to ICD-10 there has not been a clean mapping of DRGs. Therefore, especially since fourth quarter 2015, DRGs 945 and 946 have increasingly been an unreliable definition for adequately capturing rehabilitation utilization. Our revised methodology avoids this issue by only analyzing data from dedicated rehabilitation units⁷ and rehabilitation hospitals (i.e. St. Luke's Rehabilitation Institute).
- (2) Two outlier years (2010 and 2017) were removed from use-rate trend calculations (see Step 4 below). This action was taken to reflect the fact that PRMCE did not have a payer contract during these two years with one of the largest payers in the region.
- (3) Currently, a segment of Snohomish County residents out-migrate to receive care from Swedish Medical Center – Cherry Hill ("Swedish Cherry Hill"). Our revised methodology redirects 50% of the out-migration of Snohomish County resident days at Swedish Cherry Hill to "Planning Area hospitals" (i.e. PRMCE, the only existing inpatient rehab provider in the Planning Area). See Step 5 below for further detail and explanation.
- (4) The Snohomish County trend rate is incorporated to project future utilization. Please see Steps 4 and 7 below for further detail and explanation.

STEP 1: Compile state historical utilization data on rehabilitation for at least ten years preceding the base year.

Total adult (ages 15 and older) inpatient rehabilitation patient days for the period 2008-2017 were obtained from the Department of Health Office of Hospital and Patient Data Systems' CHARS database. Rehab patient days were calculated for the Snohomish County Planning Area, HSA 1, and the State of Washington as a whole.

⁶ The state is divided into four HSA's by geographic groupings. HSA 1 is composed of Clallam, Island, Jefferson, King, Kitsap, Pierce, San Juan, Skagit, Snohomish and Whatcom Counties. HSA 2 is composed of Clark, Cowlitz, Grays Harbor, Klickitat, Lewis, Mason, Pacific, Skamania, Thurston and Wahkiakum counties. HSA 3 is composed of Benton, Chelan, Douglas, Franklin, Grant, Kittitas, Okanogan and Yakima Counties. HSA 4 is composed of Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens, Walla Walla and Whitman counties.

⁷ Designated in CHARS with a 'R' suffix in the hospital identification code.

As discussed above, historically the Department has relied upon DRGs 945 and 946 as the definition for rehabilitation utilization. However, due to the conversion from ICD-9 to ICD-10 there has not been a clean mapping of DRGs. Therefore, especially since fourth quarter 2015, DRGs 945 and 946 have increasingly been an unreliable definition for adequately capturing rehabilitation utilization. Our revised methodology avoids this issue by only analyzing data from dedicated rehabilitation units (i.e. hospital identification codes with a suffix 'R') and rehabilitation hospitals (i.e. St. Luke's Rehabilitation Institute).

STEP 2: Subtract psychiatric patient days from each year's historical data.

Because this model is specific to rehabilitation days only, this step was not needed.

STEP 3: For each year, compute the planning area, statewide and HSA average rehab use rates.

The average rehab use rate (the number of rehab patient days per 1,000 total population) was derived by dividing the number of resident rehab patient days in each of the three study areas by that area's resident population (persons age 15 years and older), multiplied by 1,000. Population figures were obtained from OFM for the Snohomish County Planning Area, the HSA and the state. Average use rates were computed for all years of the historic study period: 2008-2017.

STEP 4: Using the ten-year history of use rates, compute the use rate trend line, and its slope, for each HSA and for the state as a whole.

As discussed above, the 2010 and 2017 use rate figures derived from Step 3 were deemed outlier years and removed from calculations contained in this step.

The use rate estimates for the study period, excluding outlier years, were graphed. Linear regression analysis, where use rates are regressed on time, was used to fit lines to actual observations, as presented in Figure 2, below.

The bed need methodology directs the user to select the slope coefficient of the fitted line for either the HSA or state that would create the "least pronounced" trend adjustment over the forecast period, i.e., whichever trend would result in the least change from base year use rates.⁸ However, in the revised methodology we have incorporated the Planning Area trend rate due to the following considerations:

(1) The Planning Area population, especially persons 65+ years old, is growing rapidly;

(2) This age cohort has a use rate (inpatient days per 1,000 persons) that is almost five times greater than persons less than 65 years old;

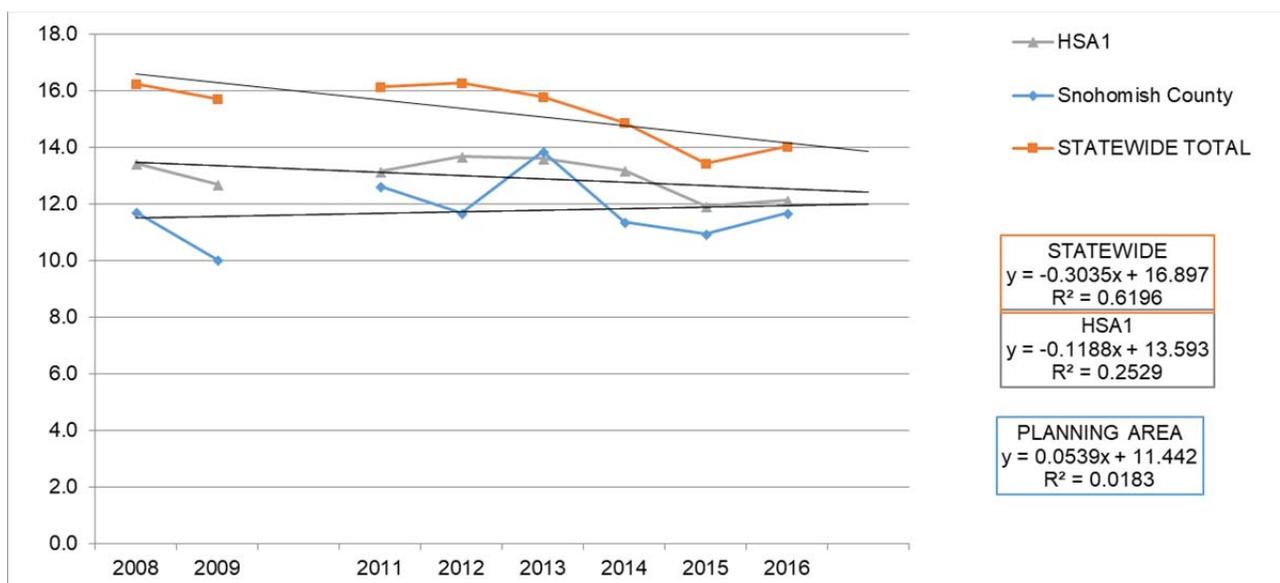
⁸ See the State Health Plan, 1987, pages C-31 and C-32.

(3) Planning Area resident rehabilitation patient days have historically grown over the prior 10 years, except for 2010 and 2017, where they declined due to insurance coverage issues, as explained above; and

(4) The Planning Area use rate does best conform to the bed need methodology, which directs the user to select the use rate that would create the “least pronounced” trend adjustment over the forecast period, i.e., whichever trend would result in the least change from base year use rates. The Planning Area use rate creates basically a constant use rate over the forecast period, whereas either the state or HSA rates would create steadily declining rates over the forecast.

In summary, the slope of the fitted line for the Snohomish County Planning Area, 0.054, has been deemed the most reasonable trend to use in the forecast model.⁹

Figure 2. Snohomish County Planning Area Use Rate Regression Analysis.



Step 5: Using the latest statewide patient origin study, allocate rehabilitation patient days reported in hospitals back to the hospital planning areas where the patients live.

Currently, some Snohomish County residents out-migrate to receive inpatient rehabilitation care at Swedish Cherry Hill. For the purposes of Step 5, our revised methodology redirects 50% of the out-migration of Snohomish County resident days at Swedish Cherry Hill to “Planning Area hospitals”. This is based on the proximity of the proposed location to the residents of South Snohomish

⁹ If, on the other hand, the HSA trend were used, it would dictate a decline in the future use rate, which would depress forecast need for beds.

County, which will allow for more convenient access to patients and their families.

The previous four steps of the methodology used patient day figures for Planning Area residents, without adjustment for whether their rehabilitation care was received inside or outside of the planning area. To determine the need for services for residents of a given planning area and for hospitals in that planning area, patient days must be counted in the planning area where the patients live and then adjusted to reflect patient flows (“migration”) into and out of the planning area. Step 5 quantifies resident migration into and out of the Snohomish County Planning Area. For this calculation, patient days were separated into two age cohorts: 15-64 and 65 and older.

For purposes of the bed need model—to estimate migration into and out of the Planning Area—the analysis divided rehab patient days into two planning areas: the Snohomish County Planning Area, and Washington State as a whole minus the Snohomish County Planning Area. The analysis indicates there was 36% out-migration of patient days of persons 15-64 years old, and 29% out-migration of patient days of persons 65 years and older from the Planning Area to hospitals in other planning areas. The analysis also indicates there was 1.03% in-migration of patient days of persons 15-64 years old, and 1.08% in-migration of patient days of persons 65 years and older from Washington residents living outside the Planning Area receiving care at Snohomish County rehabilitation providers.

Step 6: Compute each hospital planning area’s rehab use rate for each of the age groups considered (ages 15-64 and 65+).

This step estimates the age cohort-specific use rates for the year 2017, as defined in Step 3, for the Planning Area and for the rest of Washington State. *Note that the Planning Area age 65+ use rate of 26.8 patient days per 1,000 residents is almost five times the use rate for residents 15-64, which is 5.8 patient days per 1,000 residents.* Thus, as the population ages, there will be a multiplied impact on demand for inpatient days. This is very important since as detailed above, the number of residents in the 65+ age cohort is projected to increase over 5% per year through 2020, then at 4.8% over the next five years (Table 7).

Step 7A: Forecast each hospital planning area’s use rates for the target year by “trend-adjusting” each age-specific use rate. The use rates are adjusted upward or downward in proportion to the slope of either the statewide ten-year use rate trend or the Health Service Area’s ten-year use rate trend, whichever trend would result in the smaller adjustment.

As discussed in Step 4, the slope of the Snohomish County Planning Area use rate was used in our revised methodology rather than the HSA 1 or statewide trend. Use rates were forecast for the two age groups for 2017-2032.

Step 7B: Possible Adjustment for HMO populations.

Not applicable.

Step 8: Forecast rehab patient days for each hospital planning area by multiplying the area's trend-adjusted use rates for the age groups by the area's forecasted population (in thousands) in each age group at the target year. Add rehab patient days in each age group to determine total forecasted patient days.

This step takes projected use rates and population for the two age groups, then calculates total resident rehab patient days for 2017-2032. As noted previously, this analysis uses OFM population estimates and projections.

Step 9: Allocate the forecasted rehab patient days to the planning areas where services are expected to be provided in accordance with (a) the hospital market shares and (b) the percent of out-of-state use of Washington hospitals, both derived from the latest statewide patient origin study.

This step uses the 2017 in- and out-migration percentages from Step 5 and applies them to forecast rehab patient days to estimate patient days for residents who remain in the Planning Area, plus residents who in-migrate to Planning Area rehab providers. The in-migration ratio, which is used in Step 10, is calculated based on all resident rehab patient days to the Planning Area hospital divided by all Planning Area resident rehab days, by age cohort.

Step 10: Applying weighted average occupancy standards, determine each planning area's rehab bed need.

Step 10 subtracts available rehabilitation beds at PRMCE from estimated demand for beds. PRMCE has approval to operate 19 rehabilitation beds. An occupancy standard of 55% is used for this tertiary service.

In determining bed need for hospital expansion requests, the Department uses a "target year," which it currently defines for new facilities as fifteen (15) years after the last full year of actual patient day statistics. In the case of the requested project, which includes a new rehabilitation hospital, the Department would consider 2032 as its "target year". Table 8 indicates a forecast shortage of at 18.5 rehab beds in 2032, with growing shortages thereafter.

Step 11: To obtain a bed need forecast for all hospital services, including psychiatric, add the non-psychiatric bed need from step 10 above to the psychiatric inpatient bed need from step 11 of the short-stay psychiatric hospital bed need forecasting method.

This step is not applicable. The requested project proposes a new rehabilitation facility. There would be no change in the number of psychiatric beds, and further inpatient psychiatric patient days and psychiatric beds were excluded from the forecast model in Table 8.

Step 12: Determine and carry out any necessary adjustments in population, use rates, market shares, and out-of-area use and occupancy rates, following the guidelines in section IV of this Guide.

Adjustments have been made where applicable, with supporting rationale, and described above in accordance with the Department's bed need methodology.

This need methodology supports the development of a 40-bed rehabilitation hospital in Snohomish County. A hospital of this size will not only meet the growing patient demand over time, but it will also maximize design and staffing efficiencies to most effectively meet the needs of patients requiring intensive inpatient rehabilitation hospital care.

- a. **Unmet health services need of the defined population should be differentiated from physical plant and operating (service delivery) deficiencies which are related to present arrangements.**

PRMCE is the only inpatient rehabilitation service provider in the Planning Area. As discussed above, there is current (2019) need for 7.0 additional rehab beds, with need growing to 18.5 beds in 2032. Further, as stated above, without additional capacity, Planning Area residents will not have sufficient access to necessary inpatient rehabilitation care.

- b. **The negative impact and consequences of unmet needs and deficiencies should be identified.**

Please see the discussion above.

There is a current shortage of rehab beds, and that shortage is expected to grow through the forecast period (Table 8). Without the project, a greater number of Planning Area residents will have to out-migrate for rehabilitation care. Forecast shortages will increase if this request is not approved.

- c. **The relationship of the project, if any, to the appropriate service specific Performance Standards of the current State Health Plan should be fully documented in this section.**

The State Health Plan was sunset in 1989. Thus, this question is no longer applicable.

- d. **The relationship of the project, if any, to the appropriate sections of the regional health council Health Systems Plan or Annual Implementation Plan should be fully documented in this section.**

The State Health Plan was sunset in 1989. Thus, this question is no longer applicable.

2. **In the context of the criteria contained in WAC 248-19-370(2)(a) and (2)(b), document the manner in which:**

- a. **Access of low income persons, racial and ethnic minorities, women and mentally handicapped persons and other underserved groups to the services proposed is commensurate with such persons need for the health services (particularly those needs identified in the applicable Health Systems Plan as deserving of priority) and**

PRMCE is a part of Providence whose mission is to provide compassionate care to all people in need. This includes a special concern for those who are poor and vulnerable. With more than 110 years of history providing services to those in need, PRMCE turns no one away.

Table 9 provides PRMCE charity care as a percentage of total patient service revenues and adjusted total patient service revenues for 2015-2017. It also provides these percentage figures for the Puget Sound Region. The Department of Health evaluates hospital charity care based on these percentages, and it evaluates a hospital's figures in relation to one of five geographic regions. PRMCE is within the Puget Sound Region, and as Table 9 indicates, PRMCE's 3-year (2015-2017) charity care percentages are well above those for the Puget Sound Region.

Table 9. PRMCE and Puget Sound Region Charity Care, 2015-2017

		2015	2016	2017	3-Year Average
% of Total Revenue	Providence Regional Medical Center Everett	1.3%	1.1%	1.6%	1.4%
	Puget Sound Region	0.9%	0.9%	1.2%	1.0%
% of Adjusted Revenue	Providence Regional Medical Center Everett	3.8%	3.1%	4.6%	3.9%
	Puget Sound Region	2.4%	2.7%	3.7%	2.9%

Source: Washington Department of Health, Charity Care Reports, 2015-2017.

NWRH has projected its charity care deductions at 1.54% of gross revenues and 3.21% of adjusted revenues in its financial projections. NWRH commits to providing charity care at or above the regional average.

The PRMCE charity policy is available in Exhibit 15. A policy similar to this will be used adopted for at NWRH.

- b. In the case of the relocation of a facility or service, or the reduction or elimination of a service, the present needs of the defined population for that facility or service, including the needs of underserved groups, will continue to be met by the proposed relocation or by alternative arrangements.**

The project requests approval for a 40-bed inpatient rehabilitation facility. This project also includes the planned closure of the 19-bed rehabilitation unit at PRMCE. Thus, the project requests a net increase of 21 inpatient rehabilitation beds in the Planning Area, all part of the 40-bed NWRH facility.

- c. Applicants should include the following:**
- **copy of admissions policy,**
 - **copy of community service policy,**
 - **reference appropriate access problems identified in State and regional health council planning documents and discuss how this project addresses such problems,**

- **other information as appropriate.**

Please refer to Exhibit 16 for the PRMCE Admission and Patients' Rights Policy and Exhibit 17 for the PRMCE Non-Discrimination Policy, which include clear language regarding admissions and non-discrimination. Policies similar to these will be used at NWRH.

- 3. Define the population that is expected to be served by the specific project proposed. This may require different definitions for each element of the project.**

In all cases, provide regional health council population forecasts for the next ten years, broken down into age and sex categories.

In the case of an existing facility, include a patient origin analysis for at least the most recent twelve month period, if such data is maintained, or provide patient origin data from the last state-wide patient origin study. Patient origin is to be indicated by zip code, zip codes are to be grouped by city and county, and include a zip code map illustrating the service area.

The population expected to be served can be defined according to specific needs and circumstances of patients (e.g., alcoholism treatment, renal dialysis), or be the number of persons who prefer to receive the services of a particular recognized school or theory of medical care.

Please see Exhibit 6 for the Snohomish County Planning Area definition and map. Please also see Table 7 for Snohomish County Planning Area population statistics.

Exhibit 18 provides a patient origin analysis for the existing PRMCE rehabilitation inpatient, based on 2017 CHARS inpatient statistics (ages 15 and older).

- 4. Provide information on the availability and accessibility of similar existing services to the defined population expected to be served. This section should concentrate on other facilities and services which “compete” with the applicant.**

- a. Identify all existing providers of services similar to those proposed and include sufficient utilization experience of those providers that demonstrates that such existing services are not available in sufficient supply to meet all or some portion of the forecasted utilization.**

As discussed above, PRMCE is the only existing inpatient rehabilitation service provider in the Snohomish County Planning Area.

Table 8 demonstrates there is current and forecast need for additional rehabilitation beds in the Snohomish County Planning Area. As such, it is clear there is insufficient supply to meet demand and that residents require access to additional inpatient rehabilitation beds in the Planning Area.

- b. **If existing services are available to the defined population, demonstrate that such are not accessible to that population. Time and distance factors, among others, are to be analyzed in this section.**

PRMCE is the only existing inpatient rehabilitation service provider in the Snohomish County Planning Area. The establishment of a freestanding inpatient rehabilitation hospital within the Planning Area with convenient access from Interstates 5 and 405 allows more Planning Area residents to receive care within the Planning Area without unnecessarily travelling long distances and incurring additional travel costs.

- c. **If existing services are available and accessible to the defined population, justify why the proposed project does not constitute an unnecessary duplication of services.**

There is current and forecast need for additional inpatient rehabilitation beds in Snohomish County, and PRMCE is the only existing inpatient rehabilitation services in Snohomish County. The proposed NWRH project requests approval of a 40-bed facility, which would include a net increase of 21 additional inpatient rehabilitation beds, given the project also includes the planned closure of the 19-bed unit at PRMCE. As such, this project does not constitute an unnecessary duplication of services.

5. Provide utilization forecasts for each service included in the project. Include the following:

- a. **Utilization forecasts for at least three years following project completion.**

Please see Table 10 in response to application section III-B and repeated below for reference.

**Table 10. Northwest Washington Rehabilitation Hospital
Projected Utilization**

	July-December 2021	2022	2023	2024
Patient Discharges	215	474	489	504
Patient Days	2,242	5,747	5,929	6,117
Average Daily Census	12.2	15.7	16.2	16.7
# of Beds	40	40	40	40
Occupancy	30.5%	39.4%	40.6%	41.8%

Source: Applicant

- b. The complete quantitative methodology used to construct each utilization forecast.**

The methodology is thoroughly described in the response to section IV A 1 of this application.

- c. Identify and justify all assumptions related to changes in use rate, market share, intensity of service and others.**

Please see the discussion in Section IVA-1 above.

- d. Evidence of the number of persons now using the service who will continue to use the service(s). Utilization experience for existing services involved in the project should be reported for up to the last ten years, as available. Such utilization should be reported in recognized units of measure appropriate to the service. For hospitals, the workload unit of measure required by the State Hospital Commission should be reported together with the corresponding number of procedures.**

Given the historic rehabilitation utilization at PRMCE, it is evident that NWRH will have a strong position within the community and patient population who will continue to use its services. As the utilization and patient origin data provided in Exhibit 18 indicates, PRMCE provided 4,587 days of patient care in its rehabilitation unit in 2017.

Based on the current and forecast need for acute care beds in the Snohomish County Planning Area described earlier, it is reasonable to assume that residents will utilize these services.

- e. Evidence of the number of persons who will begin to use the service(s).**

The projected utilization provided in Table 10 provides a conservative estimate based on the use rate need methodology provided in Section IV A1, above. However, based on Kindred's experience operating the rehabilitation hospitals identified in Figure 1, it expects utilization to exceed these projections.

Through Kindred's joint ventures with local community partners, access to rehabilitation hospital services has improved for patients across the country, as have patient outcomes. Kindred has accomplished this improved access through its rehabilitation hospital-focused clinical liaisons and admissions teams who assist with the process of identifying and admitting patients who are appropriate for this level of care earlier in their stay at a general acute care hospital in order to place patients in the appropriate setting at the most optimal time to maximize patient outcomes. In addition, there is a strong focus on training clinical staff and developing protocols to better serve a high acuity, more complex and more functionally-impaired population than what is typically seen in inpatient rehabilitation units. These efforts ensure that patients achieve

their rehabilitation goals more quickly and regain maximum independence in order to return home or to another community-based setting.

Through implementing these strategies at all of its rehabilitation hospitals, Kindred has experienced significant increases in inpatient rehabilitation utilization at its joint venture rehabilitation hospitals with partners that had previously operated inpatient rehabilitation units. Examples of this inpatient rehabilitation utilization growth are available in Exhibit 19.

NWRH also expects that some patients currently receiving inpatient rehabilitation care outside of Snohomish County will return upon opening of the new inpatient rehabilitation hospital. The bed need methodology redirects 50% of the out-migration of Snohomish County resident days at Swedish Cherry Hill to "Planning Area hospitals". This is based on the proximity of the proposed location to the residents of South Snohomish County, which will allow for more convenient access to patients and their families.

6. **Reference all health care facility-related high priority health services needs for your service area which are called for in current health planning documents**, including the regional health council HSP and AIP and the State Health Planning and Development Agency SHP. If the resources required of this project, including health manpower, management personnel, capital and operating funds, do not address those high priority needs, justify why those resources are not reasonably available to be directed to meet such needs.

This question is not applicable.

7. **As applicable**, substantiate the following special needs and circumstances which the proposed project is to serve.
- a. **The special needs and circumstances of entities such as medical and other health professions schools, multidisciplinary clinics and specialty centers** which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service area in which the entities are located or in adjacent to health service area.

This question is not applicable.

- b. **The special needs and circumstances of biomedical and behavioral research projects** which are designed to meet a national need and for which local conditions offer special advantages.

This question is not applicable.

- c. **The special needs and circumstances of osteopathic hospitals and nonallopathic services.**

This question is not applicable.

B. FINANCIAL FEASIBILITY (WAC 246-310-220)

Note: All cost projections are to be in non-inflated dollars. Use the current year dollar value for all proforma data and projections. Do not inflate these dollar amounts.

Note: Capital Expenditure estimates should not include contingencies. Certificate of Need Statute and regulations allow a 12% or \$50,000 (whichever is greater) margin before an amendment to an approved Certificate is required.

- 1. All applicable estimated capital costs (actual or replacement costs if a conversion project).**

**Table 11 - Northwest Washington Rehabilitation Hospital
Estimated Project Costs**

Category	Cost
a. Land Purchase	
b. Utilities to lot line	
c. Land improvements	
d. Building purchase	
e. Residual Value of Facility	
f. Building Construction	
g. Fixed Equipment	\$1,103,180
h. Moveable Equipment	\$1,626,820
i. Architect/Engineer Fees	
j. Consulting Fees	
k. Site Preparation	
l. Supervision and Inspection	
m. Costs Associated with Financing to include Interim Interest	
n. Sales Tax Building Construction Equipment	\$270,000
o. Other project costs	
p. Total Estimated Project Costs	\$3,000,000

- 2. Provide a copy of a signed nonbinding contractor's estimate of the project's construction cost, moveable equipment, fixed equipment, consulting fees, site preparation, and supervision and inspection of site (Items e, f, g, i, j, and k above)**

Not applicable. NWRH is leasing the land and building from a third-party developer.

3. **For each service (cost center) provide, gross square feet to be impacted by construction, and estimated cost for items e, f, g, l, j, and k above. Separately indicate net square feet for each service (cost center). Reference appropriate recognized space-planning guidelines you have employed in your space allocation activities.**

Not applicable

4. **For an existing facility, indicate the increase in capital costs per patient day that would result from this project using the chart below**

This question is not applicable since the facility does not currently exist.

5. **Anticipated sources and amounts of financing for the proposed project (actual sources for conversions).**

**Table 12 - Northwest Washington Rehabilitation Hospital
Sources of Financing**

Category	Cost
a. Public Campaign	0
b. Bond Issue	0
c. Commercial Loans	0
d. Government Loans	0
e. Grants	0
f. Bequests and Donations	0
g. Private Foundations	0
h. Accumulated Reserves	0
i. Internal Loans	0
j. Capital Allowance	0
k. Other – Kindred Contribution	\$3,000,000
l. Total	\$3,000,000

Source: Applicant

NWRH is leasing the land and building from a developer. A letter of intent and term sheet from a potential developer are available in Exhibit 9. Kindred will provide funds for the project cost. A letter from Kindred attesting to its funding of the equipment cost is provided in Exhibit 7. The Kindred audited financial statements in Appendix 2 document its resources to provide funding for this project.

6. **For projects to be totally or partially funded from capital allowance, please indicate the amount(s) of capital allowance and budget year(s) during which the funds would be used.**

This question is not applicable since this project will not be funded from a capital allowance.

7. **Indicate the anticipated interest rate on the construction loan.**

Not applicable. NWRH will not have a construction loan.

8. **Indicate if you will have a fixed or a variable interest rate on the long-term loan and indicate the rate of interest.**

Not applicable. NWRH will lease the hospital from a third-party developer rather than incur a long-term mortgage for project financing.

9. **Estimated Start-up and Initial Operating Expenses**

- a. **Total Estimated start-up costs. (Expenses incurred prior to opening such as staff training, inventory, etc., reimbursed in accordance with Medicare guidelines for start-up costs.)**

**Table 13. Northwest Washington Rehabilitation Hospital
Projected Startup Costs**

	Amount
Preopening Staff	\$248,953
Benefits	\$49,791
Recruiting/Relocation	\$60,000
Supplies	\$175,000
Other*	\$37,000
Total	\$570,744

* (items such as license application fees, taxes and tax preparation, travel)

- b. **Estimated period of time necessary for initial start-up. (Period of time after construction completed, but prior to receipt of patients.)**

NWRH anticipates an estimated eight week startup period.

- c. **Total estimated initial operating deficits (operating deficits occurring during initial operating period.)**

The forecast revenue and expense statements available in Exhibit 20 show a projected first half of 2021 operating net loss of \$1,811,077, and positive net income results in the following years.

d. Estimated initial operating period (Period of time from receipt of first patients until total revenues equal total expenses.)

The projected initial operating period where total operating expenses equal total revenues is 47 months primarily due to the large start-up expenses and working capital requirements incurred when opening freestanding facilities that are gradually paid back over the operational ramp up period. The first month where monthly revenues exceed monthly expenses is month 4.

10. Evidence of availability of financing for the project

Please submit the following

a. Copies of letter(s) from lending institutions which indicate a willingness to finance the proposed project (both construction and permanent financing). The letter(s) should include:

- i. Status of loan application(s)**
- ii. Purpose of the loan(s)**
- iii. Proposed interest rate(s) (Fixed or Variable)**
- iv. Proposed term (period) of the loan(s)**
- v. Proposed amount of loan(s)**
- vi. Verification that the lender has examined the financial position of the borrower and found it to be adequate to support the proposal. The examination should reflect other project activity, actual or proposed, that might relate to this specific proposal.**

NWRH is leasing the land and building from a developer. A letter of intent and term sheet from a potential developer are available in Exhibit 9. Kindred will provide funds for the project cost. A letter from Kindred attesting to its funding of the building equipment is provided in Exhibit 7. The Kindred audited financial statements in Appendix 2 document its resources to provide funding for this project.

b. Copies of letter(s) from the appropriate source(s) indicating the availability of financing for the initial start-up costs. The letter(s) should include the same items requested in 5(a) above, as applicable.

Start-up funds will be provided via working capital, which will be provided by Kindred through a capital contribution to NWRH LLC. The Kindred audited financial statements in Appendix 2 document adequate funds to finance working capital for this project.

c. Copies of each lease or rental agreement related to the proposed project.

Kindred Healthcare Operating, LLC has entered into a purchase and sale agreement with Tree Owl Properties, LLC (property owner) for the site. Kindred Healthcare Operating, LLC will sell the property to a third-party developer, and the developer will construct the building and lease the land and building to NWRH. The signed purchase and sale agreement and a letter describing this process are included in Exhibit 8. In addition, a term sheet from a potential developer is available in Exhibit 9.

The Board of Managers for NWRH will make a final decision on a developer after a Request for Proposal process and will agree to a maximum price for development and construction of the proposed rehabilitation hospital through an agreement with the third-party developer. This decision will not occur until after CN approval.

d. Amortization schedule(s) for each financing arrangement including long-term, and any short-term start-up or initial operating deficit loans, setting forth the:

i. Principal

ii. Term (number of payment periods) (long-term loans may be annualized)

iii. Interest

iv. Outstanding balance at end of each payment period

Not applicable

11. Provide a cost comparison analysis, including a discussion of the advantages and costs, of each of the following alternative financing methods: purchase, lease, capital allowance, board-designated reserves, interfund loan, and commercial loan. Provide rationale for choosing the financing method selected.

The Board of Managers for NWRH will make a final decision on a developer after a Request for Proposal process and will agree to a maximum price for development and construction of the proposed rehabilitation hospital through an agreement with the third-party developer. This decision will not occur until after CN approval. NWRH's plan to use a developer for the construction and ownership of the building reduces the capital outlay and financial burden on the partners and enables NWRH to focus its efforts on caring for patients rather than financing new construction. This is a standard process Kindred has employed for many of its rehabilitation hospitals, and Kindred has vast experience in managing developer agreements and implementation of projects such as the one proposed. A term sheet from a potential developer, provided in order to estimate lease costs, is available in Exhibit 9.

The Board of Managers for NWRH will make a final decision on a developer after a Request for Proposal process and will agree to a maximum price for development and construction of the proposed rehabilitation hospital through an

agreement with the third-party developer. This decision will not occur until after CN approval.

12. **Cost center budgets anticipated revenue, and operating costs for the period from the current fiscal year through and including three full years following completion of the project, without inflation, with and without the project. In the “with” scenario, include start-up costs, and the anticipated period of deficit operations before the project is utilized at break-even point.**

Please see Exhibit 20 for the proforma income statement and financial statement assumptions.

13. **Provide a proforma balance sheet without inflation, with and without the project. However, if there are no capital costs associated with this project, no proforma balance sheets are necessary. If the project is to be totally funded from hospital reserves or capital allowances, a proforma balance sheet with the project is sufficient. Submit these statements for the period from the current fiscal year through and including three full fiscal years following completion of the project. Provide a narrative of the assumptions used in preparing these statements. Explain any extraordinary changes in financial position.**

Please see Exhibit 20 for the proforma balance sheet.

14. **Provide a capital expenditure budget covering each year starting with the first year following the last State Hospital Commission budget submittal up through the third year following completion of the project.**

The State Hospital Commission is no longer in existence; therefore, this question is not applicable.

15. **The expected sources of revenues for the applicant(s) total operations (e.g., Medicaid, Medicare, Blue Cross, Labor and Industries, etc.) with anticipated percentage of revenue from each source.**

**Table 14. Northwest Washington Rehabilitation Hospital,
Projected Sources of Revenue**

Payer	Percentage of Adjusted Revenue
Medicare PPS	47.4%
Medicare HMO	13.6%
Managed Care/Commercial	30.0%
Medicaid	7.5%
Self Pay (Charity Care)	1.5%
Total	100.0%

Source: Applicant

- 16. Provide a copy of the latest State Hospital Commission approved rate sheet.**

This question is not applicable.

- 17. Provide the complete audited year-end financial reports for the last three full fiscal years. This should include balance sheets, expense and revenue statements, statements of changes in financial position, and the accompanying notes.**

The Applicant, Northwest Washington Rehabilitation Hospital, LLC, was formed on November 17, 2017 and does not have audited financials to provide. Please see Appendix 1 for PH&S audited financials for years 2015 and Providence St. Joseph Health audited financials for 2016 and 2017.

As a new entity, Kindred Development 12, L.L.C. does not have audited financials to provide.

On July 2, 2018, Kindred Healthcare, Inc. completed a transaction in which its outstanding shares were acquired by a consortium of private investors. In connection with that transaction, Kindred Inc. was split into two companies. Kindred Inc.'s long-term acute care hospitals, inpatient rehabilitation facilities and contract rehabilitation services business are now owned and operated by its renamed successor, Kindred Healthcare, LLC and various subsidiaries (collectively, Kindred Healthcare). The remaining home health, hospice, and community care businesses previously belonging to Kindred Inc. were split off under a separate unrelated entity. In response to this request, Appendix 2 includes the audited financial statements from the 2015, 2016, and 2017 10-Ks for Kindred Healthcare, Inc. (Kindred Inc.), and the audited financial statements for 2018, which include six months of financial information for the predecessor company, Kindred Healthcare, Inc. and six months of financial information for the successor company, Kindred Healthcare, LLC.

- 18. The relationship of the project, if any, to the appropriate cost sections of the State Health Plan, regional health council health systems plan or annual implementation plan should be documented.**

The State Health Plan was sunset in 1989. Therefore, this question is not applicable.

- 19. Indicate the reduction or addition of FTEs with the salaries, wages, employee benefits for each FTE affected.**

Please see Exhibit 21 for the proposed staffing schedule.

C. STRUCTURE AND PROCESS (QUALITY) OF CARE (WAC 246-310-230)

1. Document the following

- a. The availability of sufficient numbers of qualified health manpower and management personnel. If staff availability is a problem, describe the manner in which the problem will be addressed.**

NWRH does not anticipate any staffing challenges. Providence has multiple resources available to assist with the identification and recruitment of appropriate and qualified personnel: Experienced recruitment teams within Providence to recruit qualified manpower; strong success in recruiting for critical to fill positions with recruiters that offer support on a national level as well as local level; career listings on the Providence web site and job postings on multiple search engines and listing sites; educational programs with local colleges and universities as well as the Providence University in Great Falls, MT. Additionally, PRMCE is actively involved in the training of future health care personnel and partners with many educational institutions throughout the Northwest to serve as a training site for students from various disciplines who wish to prepare themselves for a future in a healthcare related field. These training programs provide a large pool of new health care professionals to the community and serve as an ongoing source for recruiting new personnel to NWRH.

Kindred also has clinical education agreements with several universities and schools to provide clinical rotations for physical therapy, occupational therapy, speech therapy, nursing and pharmacy students. These include Bates Technical College, Eastern Washington University, Edmonds Community College Green River Community College, Lake Washington Institute of Technology, Olympic College, PIMA Medical Institute, Spokane Falls Community College, University of Puget Sound, University of Washington, Washington State University, and Whatcom Community College. These education opportunities will also serve as a strong source of therapist referrals to the new Rehabilitation Hospital.

NWRH will continue to implement PRMCE's recruitment strategies and build on established affiliations with area schools to continue to provide clinical rotations for these students. As a result of these partnerships, PRMCE and Kindred expect to have access to sufficient staff levels for the new Rehabilitation Hospital.

- b. In the context of the State Health Plan Health Survey/Service General Performance Standard #2h, document the present and future availability of personnel with qualifications appropriate to the level and intensity of care they are and/or will be providing and with training specific to the technologies they are using.**

As noted above, NWRH does not anticipate any staffing challenges.

- 2. Describe the relationship of ancillary and support services to proposed services, and the capability of ancillary and support services to meet the service demands of the proposed project.**

NWRH will establish a purchased services agreement for any necessary ancillary services with PRMCE.

- 3. In the context of the State Health Plan Health Facility/Service General Performance Standard #2f, document that the facility has and/or will have written policies evidencing a coordination and referral system that assures that patients receive care at the least intensive and restrictive level appropriate to their needs.**

NWRH will adopt a policy similar to the PRMCE Transition Planning Referral policy available in Exhibit 22.

At each of its facilities, Kindred provides comprehensive acute rehabilitation services to meet the medical, functional, psychological, social and support needs of patients and their families. Rehabilitation physicians, nurses, and therapists will meet regularly to discuss each patient's progression, establish individual goals and timelines, and establish parameters for discharge planning that include family/caregiver preparation. The onsite interdisciplinary team will work as a collaborative unit of professional specialists whose shared goal is the individual patient's optimal functional recovery and return to their community.

Each patient will have a discharge care plan that begins prior to or at admission. As discharge gets closer, the plan would either be modified or implemented, depending upon the needs of the patient. NWRH will develop strong and positive working relationships with other entities that provide lower level of care options for patients. This will ensure that patients are in the most appropriate level of care, and that any post discharge plans are fully coordinated prior to discharge.

- 4. Identify the specific means by which the proposed project will promote continuity in the provision of health care to the defined population and avoid unwarranted fragmentation of services. This section should include the identification of existing and proposed formal working relationships with hospitals, nursing homes and other health services resources serving your planning area. This description should include recent, current and pending cooperative planning activities, shared service agreements, and transfer agreements. Copies of relevant agreements and other documents should be included.**

PRMCE has developed long-term collaborative relationships with other providers to expand program offerings and ensure access and continuity of appropriate care for residents of Snohomish County. PRMCE coordinates patient access to other Providence entities as well as community providers to ensure continuity of care during hospital discharge to other levels of care as well as when other facilities need to transfer patients to PRMCE for more advanced care. Those providers include hospitals, hospice, home care, long-term care facilities, psychiatric care, assisted living and other providers.

NWRH will utilize the relationships PRMCE has developed to ensure appropriate transfer options based on each patient's specific needs.

- 5. In the context of the State Health Plan Health Facility/Service General Performance Standard #2g, document that your facility ensures and /or will ensure effective continuity of care through discharge planning initiated early in the course of treatment.**

Please see the response to Question #3.

- 6. In the context of the State Health Plan Health Facility/Service General Performance Standard #2c, document that your facility has and/or will have a patient priority policy which requires acceptance of patients according to clinical evidence of medical need and potential benefit to patients.**

Please see the PRMCE Admissions policy in Exhibit 16 and Nondiscrimination policy in Exhibit 17. NWRH will adopt a similar policy upon commencement of operations.

- 7. Fully describe any history of each applicant with respect to the actions noted in Certificate of Need regulations WAC 248-19-390(5)(a). If there is such a history, provide clear, cogent and convincing evidence that the proposed project will be operated in a manner that ensures safe and adequate care to the public to be serves and in conformance with applicable federal and state requirements.**

Neither Northwest Washington Rehabilitation Hospital, nor its members, Providence Health & Services-Washington and Kindred Development 12, L.L.C., has any history as described in WAC 246-310-230 (5)(a). (Note: the above WAC has been re-codified as WAC 246-310-230(5)(a).) Patient care at Northwest Washington Rehabilitation Hospital will be provided in conformance with all applicable federal and state requirements.

NWRH will obtain all required federal and state licenses and certifications, and it will also seek accreditation from The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities (CARF).

- 8. Demonstrate that services to be provided will be provided (a) in a manner that ensures safe and adequate care, and (b) in accord with applicable federal and state laws, rules and regulations.**

NWRH will operate in compliance with all applicable federal and state laws, rules and regulations for the operation of a high quality health care facility; consistent with the past experience of the members of NWRH.

Established in 1978, PRMCE's inpatient rehabilitation unit is currently licensed to operate 19 Level II Rehab beds, and Kindred has been providing management services for the unit since 2010. CARF, the Commission on Accreditation of Rehabilitation Facilities, awarded the PRMCE Inpatient Rehabilitation Unit a

three-year accreditation in 2016. CARF accreditation means that patients can be confident that this organization has made a commitment to continuously enhance the quality of services and programs and focus on customer satisfaction. Additionally, PRMCE is accredited by the Joint Commission further demonstrating its commitment to the highest standards in quality care.

PRMCE’s partnership with Kindred will further its commitment to quality care. Kindred believes in continuous measurement of patient outcomes as a means to evaluate its clinical programs and quality. Kindred uses the Uniform Data System for Medical Rehabilitation (UDSMR) UDS-PRO Doc™ System. As illustrated by the data below, on a national severity adjusted basis, Kindred’s rehabilitation hospitals are consistently more efficient in improving patients’ functioning per day of therapy and more efficient in achieving patient discharges to the community, as compared to the national average. This is especially remarkable because Kindred’s rehab patients are more acute and have lower function when they are admitted to Kindred’s rehab hospitals, as compared to the national average. Through Kindred’s joint ventures, access to IRF services has improved, as have patient outcomes. Kindred has accomplished this through its IRF focused clinical liaisons and admissions teams who assist with the process of admitting patients who are appropriate for this level of care. In addition, there is a strong focus on training clinical staff and developing protocols to better serve a high acuity, more complex and more functionally impaired population than what is typically seen in inpatient rehabilitation units.

Table 15 – Kindred Rehabilitation Hospital Clinical Quality Indicators

Key Metrics: Kindred vs. UDS Nation				
Clinical Indicators¹	Kindred IRFs	UDS Nation	Variance	% Variance
Case Mix Index	1.43	1.34	0.09	6.6%
Qualifying Comorbid Condition	63.5%	57.5%	5.8%	10.1%
Admission FIM Score	54.5	55.4	(0.9)	(1.7%)
FIM Gain	36.3	32.8	3.5	10.8%
LOS Efficiency	3.40	2.81	0.59	21.1%
Discharge to Community	78.8%	75.5%	3.3%	4.4%
Discharge to SNF	10.9%	13.2%	(2.3%)	(17.6%)
Transfer To Acute Care	9.8%	10.5%	(0.7%)	(7.0%)

¹ Data per UDS-PRO Rehab Metrics Report (Nation Adjusted Version); FY2018

As described below, Kindred’s performance has been favorable compared to its peers. Please note that, depending upon the indicator, either positive or negative values may reflect favorable performance.

- Case Mix Index – Kindred’s rehab patients are more acute

- Qualifying Comorbidity % - Kindred's rehab patients come to the facilities with more medical issues occurring at the same time
- Admission FIM – Kindred's rehab patients have a lower Functional Independence Measure (FIM) upon admission, meaning they are more acute
- FIM Gain – Kindred's rehabilitation patients achieve greater functional mobility independence through its rehabilitation services
- LOS Efficiency - Kindred's rehab patients achieve quicker functional improvement per day
- Discharge to Community – More of Kindred's rehab patients are able to be discharged to the community
- Discharge to SNF – Fewer of Kindred's rehab patients need to be discharged to a SNF
- Transfer to Acute Care – Fewer of Kindred's rehab patients need to be transferred to an acute care hospital

In 2018, 16 of Kindred's then-19 eligible inpatient rehabilitation facilities finished in the top 25th percentile of UDSMR[®] Uniform Data System for Medical Rehabilitation's Program Evaluation Model. This evaluation process uses the measures of efficiency and effectiveness included in the Centers for Medicare and Medicaid Services' Inpatient Rehabilitation Facility Patient Assessment Instrument to recognize high-performing rehabilitation hospitals for their delivery of quality patient care. Six of those rehabilitation hospitals were in the top 10 percentile and one, Texas Rehabilitation Hospital of Fort Worth, ranked in the top 3 percentile.

9. Describe how the project complies with the appropriate Quality and Continuity of Care related criteria of the State Health Plan, regional health council systems plan or annual implementation plan.

Neither the State Health Plan nor the Health Systems Plan is currently in effect. As such, this question is not applicable.

10. In the context of the State Health Plan Health Facility/Service General Performance Standard #2b, document that your facility has and/or will have an active utilization review program.

NWRH will have an interdisciplinary care team consisting of rehabilitation physicians, nurses, and therapists that will meet regularly to discuss each patient's progression, establish individual goals and timelines, and determine when the patient is medically appropriate for another level of care. It will develop a discharge plan as described above to return the patient to the highest functioning condition and most appropriate environment post discharge.

D. COST CONTAINMENT (WAC 246-310-240)

Document the following:

- 1. Exploration of alternatives to the project you have chosen to pursue, including postponing action, shared service agreements, merger, contract services, and different spatial configurations you have evaluated and rejected. Each alternative should be analyzed by application of the following:**
 - i. Decision making criteria (e.g., cost limits, availability, quality of care, legal restrictions, etc.)**
 - ii. Advantages and disadvantages, and whether the sum of either the advantages or disadvantages outweigh each other by application of the decision-making criteria**
 - iii. Capital costs**
 - iv. Staffing impact**

Both PRMCE and Kindred considered multiple alternatives to evaluate the best approach to meet the needs of patients in Snohomish County requiring inpatient rehabilitation care.

The alternatives considered include:

- Do nothing: continue to operate the rehabilitation unit at PRMCE with no expansion;
- Expand the PRMCE rehabilitation unit
- Develop a second Rehabilitation Unit in the Service Area
- Integrate the PRMCE rehabilitation unit into a new joint venture rehabilitation hospital.

No Project Option

The Applicant considered doing nothing and continuing to operate the PRMCE rehabilitation unit as is. However, as documented in the bed need analysis in response to question Section IV A, the need for inpatient rehabilitation hospital beds in Snohomish County is significant. In addition, the growth in population of the Service Area will further necessitate the development of additional inpatient rehabilitation services. As a result of the bed need for additional inpatient rehabilitation beds, combined with the area population growth, this alternative was rejected.

PRMCE Rehabilitation Unit Expansion

The Applicant considered the alternative of expanding the rehabilitation unit at PRMCE. However, a thorough building assessment determined that adequate space does not exist within the existing building for a 40-bed unit and all necessary therapy and support spaces to facilitate ideal outcomes for patients. Therefore, due to the limitations of the existing space, this alternative was rejected.

Development of Second Rehabilitation Unit within the Service Area

The Applicant considered the development of a second 21-bed rehabilitation hospital or unit to meet the additional need for inpatient rehabilitation services in Snohomish County. This would require significant capital expenditure and the establishment of duplicative services at each site in order to meet the inpatient rehabilitation needs of the patients at each location. This would result in significant inefficiencies in delivery of care and unnecessary expense. For these reasons this alternative was rejected.

Joint Venture Inpatient Rehabilitation Hospital – Proposed Project

PRMCE evaluated the alternative of a joint venture partnership to establish a freestanding rehabilitation hospital. Combining its reputation as a trusted provider of high quality medical care throughout the Snohomish County service area with Kindred, an experienced provider of inpatient rehabilitation services with proven success in local community partnerships and history of service to western Washington, was determined to be the best option to most appropriately meet the inpatient rehabilitation needs of patients in Snohomish County. In addition, the plan to use a real estate investment trust for the construction and ownership of the building reduces the capital outlay and financial burden on the partners, and enables both PRMCE and Kindred to focus their efforts on caring for patients rather than financing new construction. For all of the above reasons, a joint venture partnership with PRMCE and Kindred for the development of a freestanding rehabilitation hospital was determined to be the best alternative.

2. The specific ways in which the project will promote staff or system efficiency or productivity

The inpatient rehabilitation hospital is designed to maximize staff efficiency and patient care. The development of a freestanding facility enables the Applicant to create an environment most conducive to system efficiency and patient outcomes. Designated patient room wings for stroke and traumatic brain injury patients enables nurses to more effectively care for these special patient populations, and a complete therapy suite on the first floor plus therapy spaces on each floor allow for convenient access for the entire patient population. Additionally, an all-private room and private bathroom facility allows for patients' comfort and treatment needs with maximized privacy as well as adequate space for families.

3. In the case of construction, renovation or expansion, capital cost reductions achieved by architectural planning and engineering methods and methods of building design and construction.

This building design is a prototypical plan that has been developed with the purpose of operational efficiency and cost reduction. The areas of focus for this facility are the patient care areas that have been sized appropriately to accommodate all the staffing and material needs required to provide superior clinical service to the patients. The building was designed as a two story structure to keep all the patient services/amenities (Therapy Gym, Dining, Open Courtyard) convenient to the patients in regards to travel distance as well as efficient for the staff.

The construction costs are further managed through the use of efficient building systems. The footprint of the facility allows for fully contained packaged air handler units as well as smaller, more efficient boilers due to the shorter runs of domestic water and ductwork. This yields lower construction costs than typical facilities incur as well as lower operational costs. Additionally, as this is a prototypical design, the inherent knowledge that is gained as each project is completed yields more efficient construction delivery and better cost management.

4. In the case of construction, renovation or expansion, an analysis of the capital and operating costs of alternative methods of energy consumption, including the rationale for choosing any method over the least costly.

Within the prototypical facility design, the developer will incorporate numerous energy saving practices. All glass is high density Low E Glass that is hermetically sealed in the frames which minimizes heat loss. The heating, ventilation and air conditioning units are all Intellipack packaged air units with internal reheat devices that allow a greater use of outside air, which keeps the unit operation low. The building itself is oriented to maximize the daylight and heat load from the sun. This cuts down on heating costs in the winter and allows for more natural light to enter the areas of care. While initial cost is a factor, the long term operational costs are also considered. For instance, it is more costly on the front end to utilize LED lamps in the light fixtures, however, the lower heat load and lower electrical costs yield a 3-5 year payback which offsets the higher upfront costs.

Exhibit 1

CN Application Filing Fee Check

Kindred Healthcare Operating, Inc.

Attn: A/P Department
680 South Fourth Street
Louisville, KY 40202

CHECK DATE 03/20/2019 CHECK NUMBER 0000009963872
VENDOR NO 690704

InvDt/FacNo.	InvoiceNo/Description	Purchase Order No.	Invoice Amount	Discount Amt	Invoice Net
03/01/2019 3320	3012019 ACCOUNTS PAYABLE DEPARTMENT LOUISVILLE KY 40202 (877)798-6820 +AP+SANDY STATEN KH3 CON APPLICATION FILING FEE-		40,470.00	0.00	40,470.00
Total			40,470.00	0.00	40,470.00

FOLD

FOLD

FOLD

FOLD

VERIFY THE AUTHENTICITY OF THIS MULTI-TONE SECURITY DOCUMENT.

CHECK BACKGROUND AREA CHANGES COLOR GRADUALLY FROM TOP TO BOTTOM.

Kindred Healthcare Operating, Inc.
Attn: A/P Department
680 South Fourth Street
Louisville, KY 40202

BNY Mellon Trust of Delaware
Newark, DE

62-35
31T DATE 03/20/2019

09963872

PAY THIS AMOUNT \$ ***40,470.00***

FORTY THOUSAND FOUR HUNDRED SEVENTY Dollars and 00/100

Pay to the Order of
WASHINGTON STATE DEPT OF HEALTH
111 ISRAEL RD SE
TUMWATER WA 98501

Non-Negotiable After 120 Days



Authorized Agent(s) of the Corporation

⑈09963872⑈ ⑆031100351⑆ ⑈0300951043⑈

Exhibit 2

Letter of Intent



March 1, 2019

Janis Sigman, Manager
Certificate of Need Program
Washington State Department of Health
111 Israel Road SE
Olympia, WA 98504-7852

RECEIVED

MAR 04 2019

CERTIFICATE OF NEED PROGRAM
DEPARTMENT OF HEALTH

Dear Ms. Sigman:

Please accept this letter of intent pursuant to WAC 246-310-080 Washington Administrative Code on behalf of Northwest Washington Rehabilitation Hospital, LLC to establish an acute inpatient rehabilitation hospital in Snohomish County.

Description of Proposed Service

Northwest Washington Rehabilitation Hospital, LLC intends to file a Certificate of Need application to establish a 40-bed acute inpatient rehabilitation hospital in Snohomish County.

Estimated Cost of the Project

The estimated project cost is \$3,000,000. The applicant will lease and operate the facility.

Description of Service Area

The service area for this proposed acute inpatient rehabilitation hospital is Snohomish County.

Please contact Heidi Aylsworth with any questions at heidi.aylsworth@swedish.org or 206-628-2552 about this letter of intent.

Sincerely,

Kim Williams

CEO, Providence Health & Services
Northwest Washington

Martin Mann

Senior Vice President - Strategic Partnerships
Kindred Healthcare

Exhibit 3

Northwest Washington Rehabilitation Hospital, LLC
Secretary of State Registration



Office of the Secretary of State
Corporations & Charities Division

James M. Dolliver Building
801 Capitol Way South • PO Box 40234
Olympia, WA 98504-0234
Tel: 360.725.0377
www.sos.wa.gov/corps

Congratulations:

You have completed the initial filing to create a new business entity. **The next step in opening your new business is to complete a Business License Application.** You may have completed this step already. The Business License Application can be completed online or downloaded at:
<http://www.bls.dor.wa.gov/>.

If you have any questions about the Business License Application, or would like a Business License Application package mailed to you, please call the Department of Revenue at 1-800-451-7985.

If you have questions about annual reports or registered agent requirements, please contact the Corporations Division at 360-725-0377 or visit our website at: <http://www.sos.wa.gov/corps>.

C T CORPORATION SYSTEM
711 CAPITOL WAY S STE 204
OLYMPIA WA 98501 UNITED STATES

IMPORTANT

To keep your filing status active and avoid administrative dissolution, you must:

1. **File an Initial Report** within 120 days of the date your corporation or limited liability company (LLC) was filed. The date of filing is stated on your certificate. Please go online to file your initial report at www.sos.wa.gov/ccfs.
2. **File an Annual Report** each year before the anniversary of the filing date for the entity. The registered agent will be sent notice of the Annual Report requirement. It is the corporation or LLC's responsibility to file the report on time even if no notice is received.
3. **Maintain a Registered Agent** and registered office in this state. You must file a statement of change or designation of registered agent if there are any changes in your registered agent, agent's address, or registered office address. Failure to file changes with the Corporations Division will result in misrouted mail, and possibly lead to administrative dissolution.

If you have questions please contact our office at: corps@sos.wa.gov, 360-725-0377, or visit our website www.sos.wa.gov/corps.

UNITED STATES OF AMERICA

The State of



Washington

Secretary of State

I, KIM WYMAN, Secretary of State of the State of Washington and custodian of its seal, hereby issue this

CERTIFICATE OF FORMATION

to

NORTHWEST WASHINGTON REHABILITATION HOSPITAL, LLC

A WA LIMITED LIABILITY COMPANY, effective on the date indicated below.

Effective Date: 11/17/2017

UBI Number: 604 193 186



Given under my hand and the Seal of the State
of Washington at Olympia, the State Capital

Kim Wyman, Secretary of State

Date Issued: 11/17/2017



Office of the Secretary of State
Corporations & Charities Division

Limited Liability Company
See attached detailed instructions

- Filing Fee \$180.00
- Filing Fee with Expedited Service \$230.00

This Box For Office Use Only

FILED
Secretary of State
State of Washington
Date Filed: 11/17/2017
Effective Date: 11/17/2017
UBI No: 604 193 186

UBI Number:

CERTIFICATE OF FORMATION
Chapter 25.15 RCW

SECTION 1

NAME OF LIMITED LIABILITY COMPANY:
Northwest Washington Rehabilitation Hospital, LLC
(Must contain one of the following designations: Limited Liability Company, Limited Liability Co or one of these abbreviations: L.L.C. or LLC. If the designation is omitted, it will default to LLC when processed)

SECTION 2

ADDRESS OF THE PRINCIPAL OFFICE:
Street Address 680 South Fourth Street City Louisville State KY Zip 40202
PO Box _____ City _____ State _____ Zip _____

SECTION 3

EFFECTIVE DATE OF FORMATION: *(Please check one of the following)*

- Upon filing by the Secretary of State
- Specific Date: _____ *(Specified effective date must be within 90 days AFTER the Certificate of Formation has been filed by the Office of the Secretary of State)*

SECTION 4

TENURE: *(Please check one of the following and indicate the date if applicable)*

- Perpetual existence
- Specific term of existence _____ *(Number of years or date of termination)*

SECTION 5

Effective Date: 11/17/2017

UBI No: 604 193 186

DESIGNATION OF REGISTERED AGENT: **SELECT ONLY ONE AGENT TYPE (RCW 23.95)**

<input checked="" type="checkbox"/> Commercial Agent	<input type="checkbox"/> Noncommercial Agent (most common)	<input type="checkbox"/> Office or Position
C T Corporation System	NAME	NAME
<i>NAME ONLY of Commercial Registered Agent as recorded with the Secretary of State. (Address of Commercial Registered Agent is already on file)</i>	<i>Name of Noncommercial Registered Agent. (Any person or business not registered as a Commercial Registered Agent, must also include the physical address below)</i>	<i>List the Office or Position serving as agent. (Only if using the specific office or position as the registered agent, no matter who holds the position like: Secretary, Member, Treasurer, must also include the physical address below)</i>

Washington State Physical Address (Required Only for Noncommercial, Office, or Position):

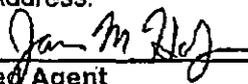
Address _____
City _____ WA Zip Code _____

Washington State Alternate Mailing or Postal Address (optional):

Address _____
City _____ WA Zip Code _____

REQUIRED ALL - CONSENT TO SERVE AS REGISTERED AGENT:

I hereby consent to serve as Registered Agent in the State of Washington for the above named entity. I understand it will be my responsibility to accept service of process, notices, and demands on behalf of the entity; to forward mail to the entity; and to immediately notify the Office of the Secretary of State if I resign or change the Registered Office Address.

X By: C T Corporation System		James M. Halpin	Assistant Secretary	11/15/17
	Signature of Registered Agent		Printed Name/Title	Date

SECTION 6

NAME, ADDRESS AND SIGNATURE OF EACH EXECUTOR:

(If necessary, attach additional names, addresses and signatures)

Name: Jeffrey Stodghill
Address: 680 South Fourth Street City Louisville State KY Zip Code 40202

This document is hereby executed under penalties of perjury, and is, to the best of my knowledge, true and correct.

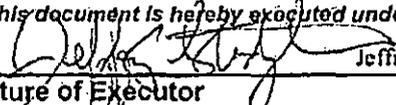
X 	Jeffrey Stodghill	11/15/17	502-596-7044
Signature of Executor	Printed Name	Date	Phone

Exhibit 4

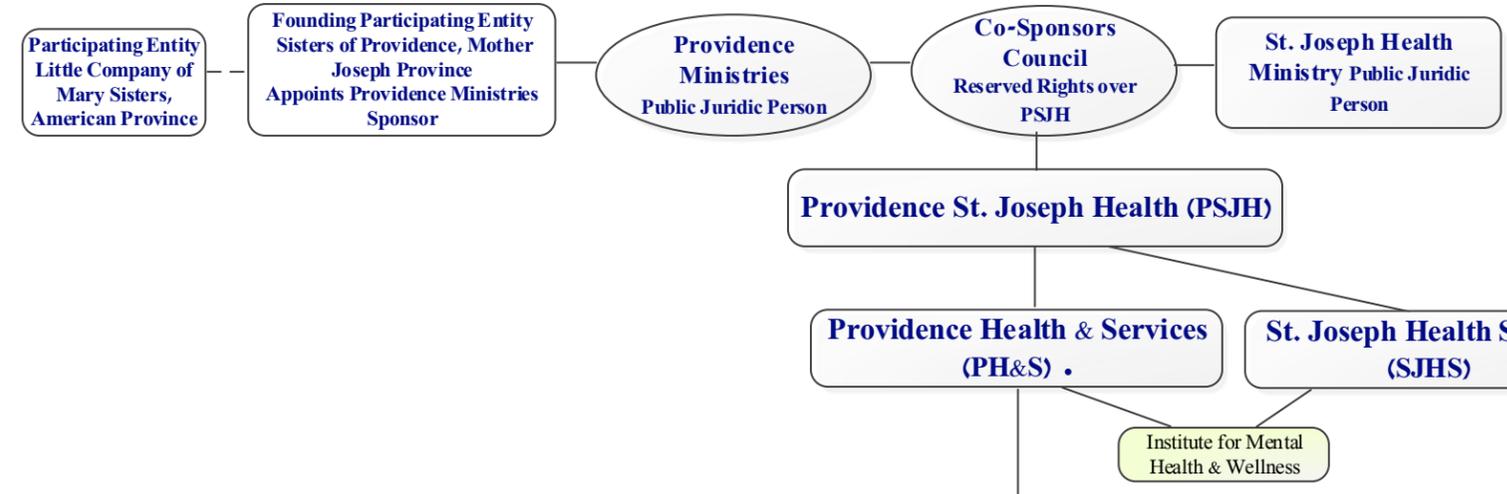
Organizational Structure

Northwest Washington Rehabilitation Hospital, LLC

Kindred Healthcare, LLC

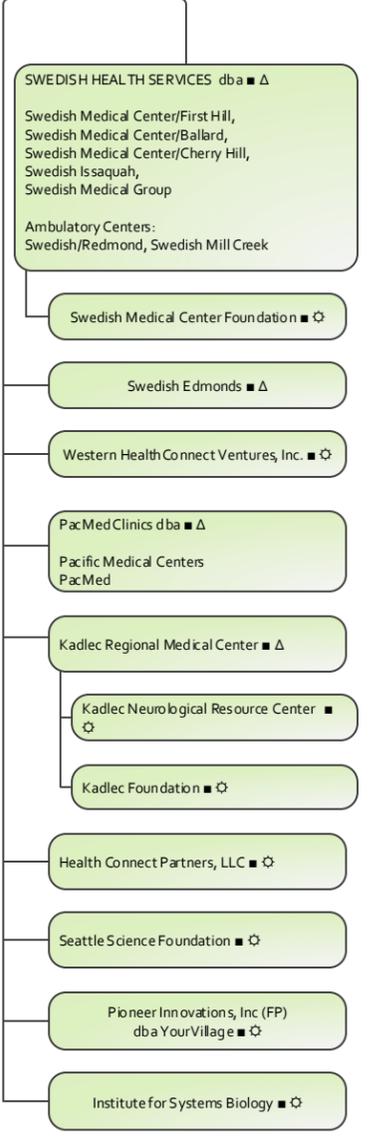
Providence Health and Services

LEGAL STRUCTURE
PROVIDENCE HEALTH & SERVICES AND WESTERN HEALTHCONNECT

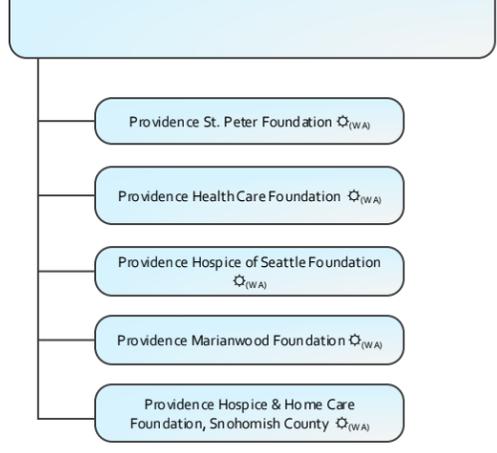


See separate SJHS org chart on page 2

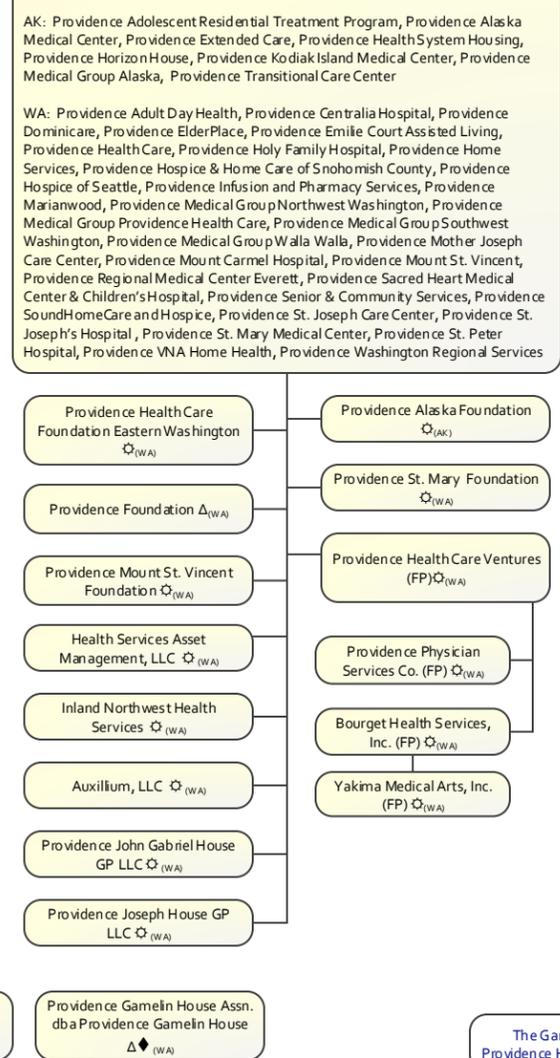
WESTERN HEALTHCONNECT ■ Δ



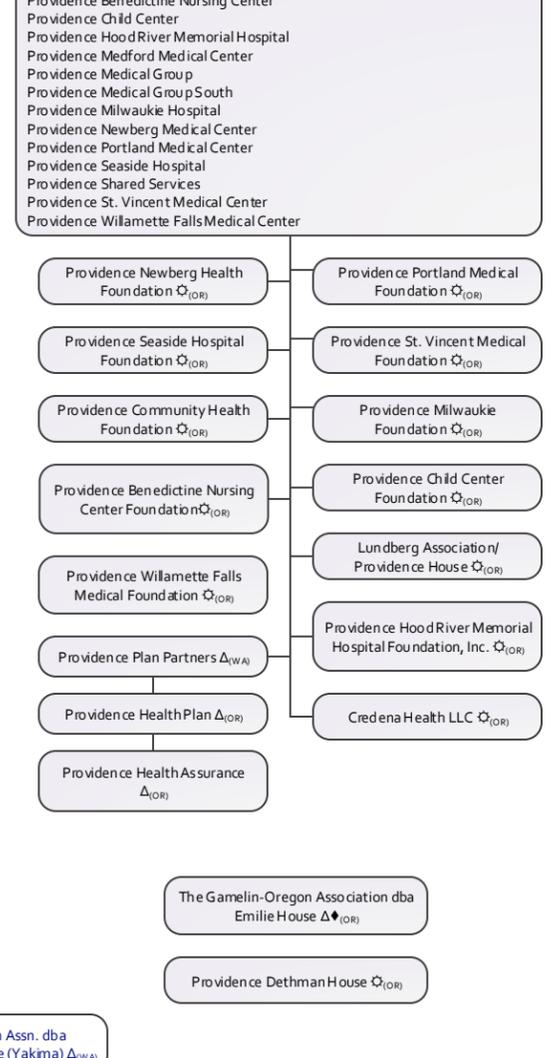
PROVIDENCE HEALTH & SERVICES – WESTERN WASHINGTON Δ



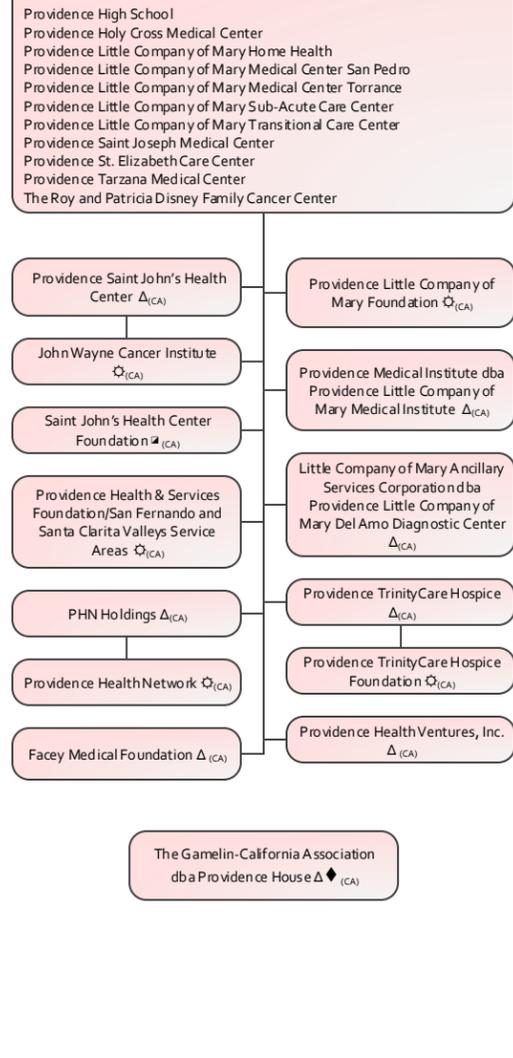
PROVIDENCE HEALTH & SERVICES – WASHINGTON dba Δ



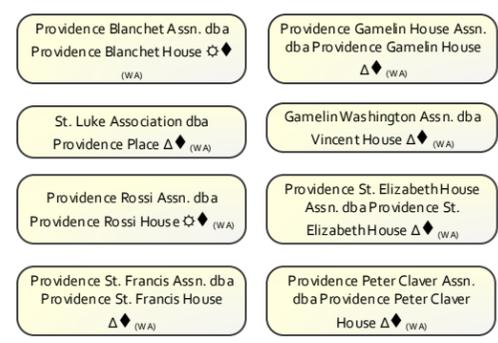
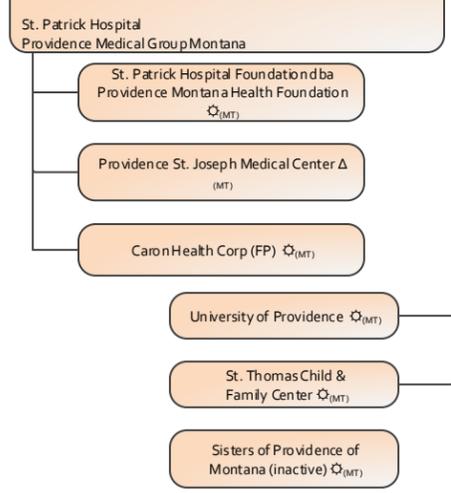
PROVIDENCE HEALTH & SERVICES—OREGON dba Δ



PROVIDENCE HEALTH SYSTEM—SOUTHERN CALIFORNIA dba Δ

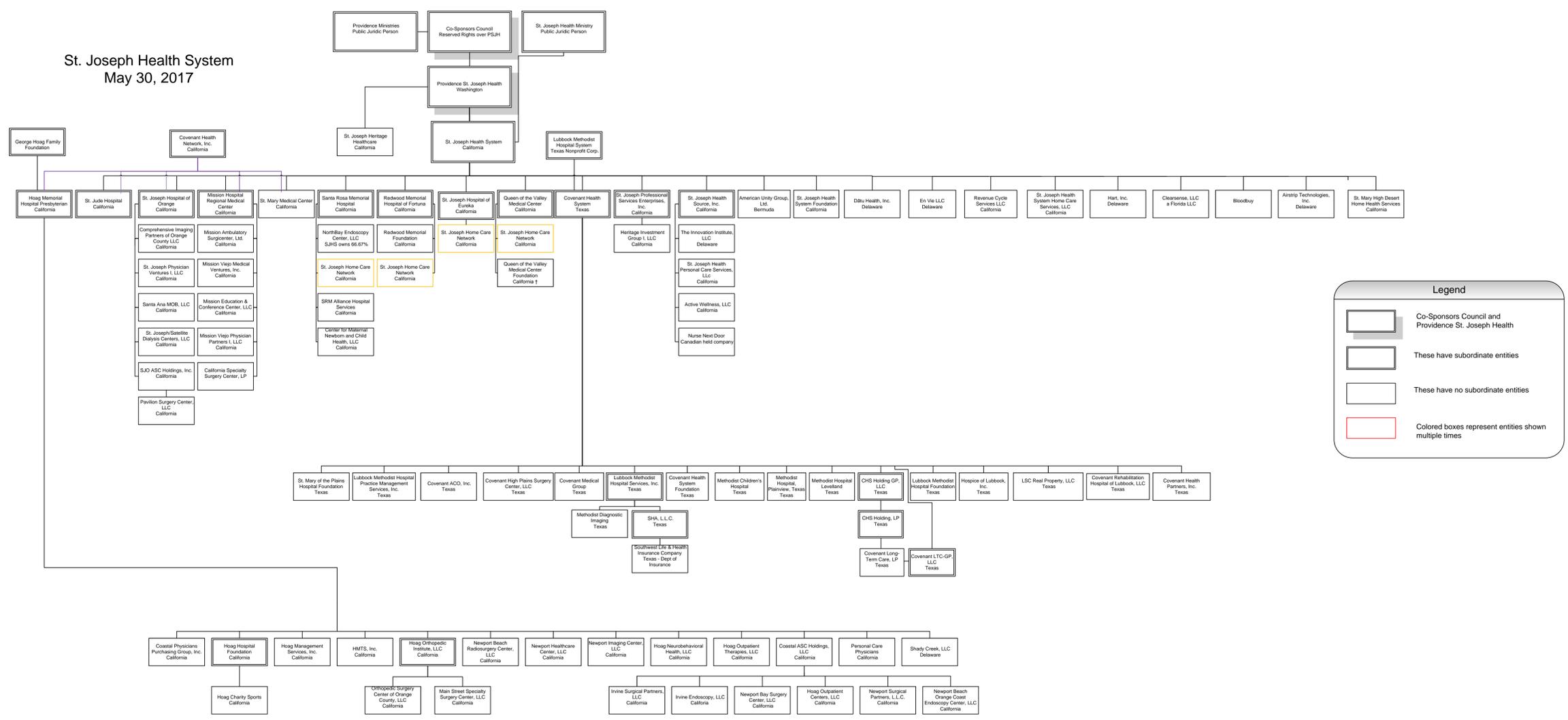


PROVIDENCE HEALTH & SERVICES—MONTANA dba Δ



LEGEND:
 ⚙ Entity's Board of Directors differs from Providence Health & Services' Board
 Δ Entity's Board of Directors identical to Providence Health & Services' Board
 ■ Entity's Members: Providence Health System – Southern California and Saint John's Health Center Foundation Governance, Inc.
 ● Entity's Member is Providence St. Joseph Health
 ◆ Entity's Member is Sisters of Providence
 • Canonical Entity
 ■ Secular Entity
NOTE: Does not include joint ventures or other non-wholly owned entities

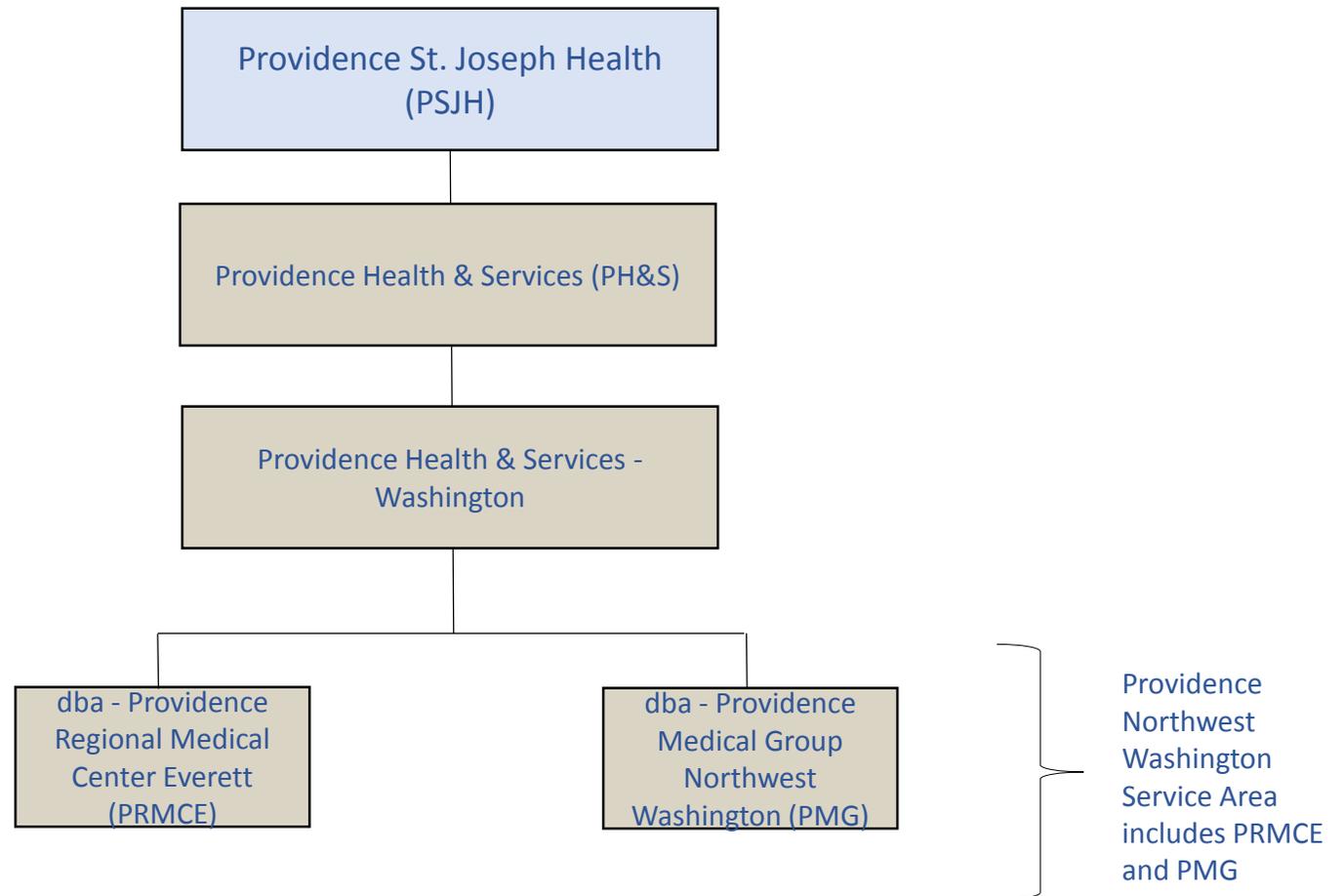
St. Joseph Health System
May 30, 2017



Legend

- Co-Sponsors Council and Providence St. Joseph Health
- These have subordinate entities
- These have no subordinate entities
- Colored boxes represent entities shown multiple times

Providence Northwest Washington Service Area Organizational Chart



Kindred Healthcare, LLC to Kindred Development 12, LLC Organizational Chart



Northwest Washington Rehabilitation Hospital, LLC Organizational Chart

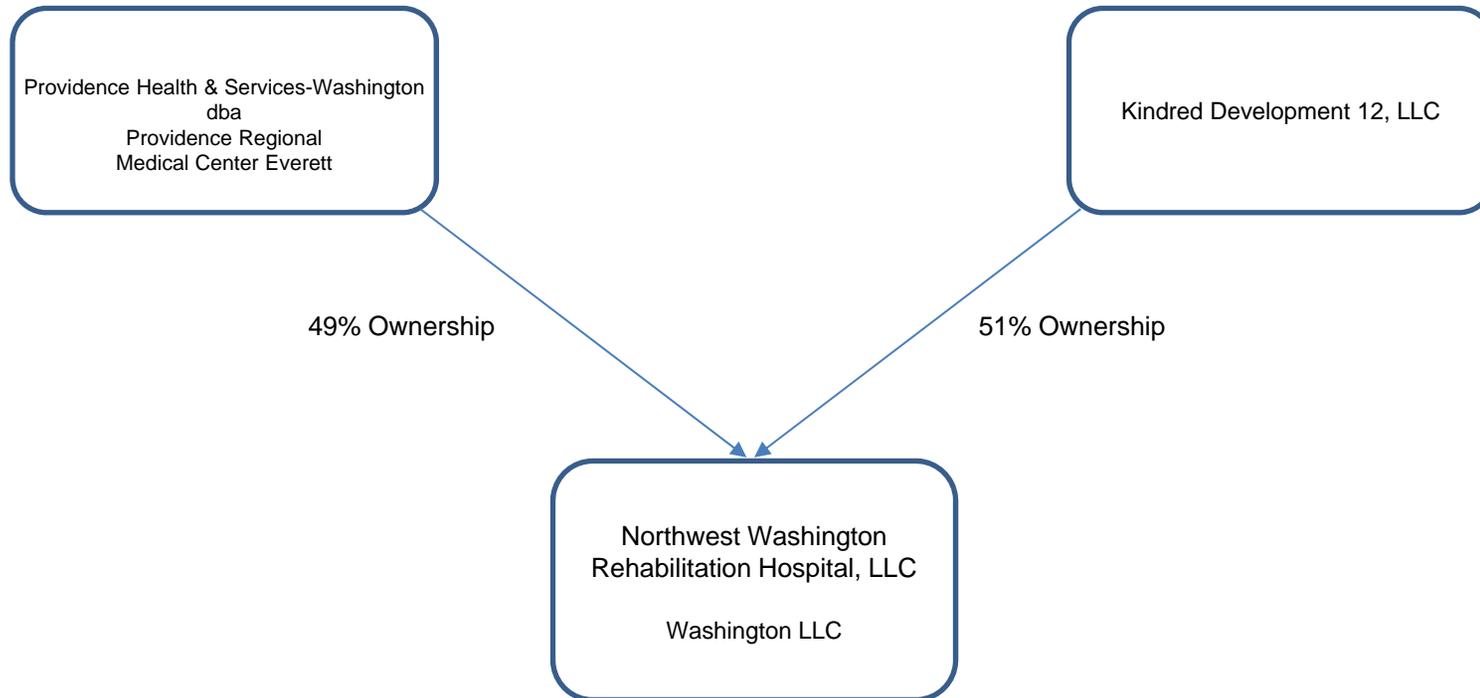


Exhibit 5

Facility Listings Providence Health and Services and Kindred Healthcare, LLC

Providence Acute Care Hospitals

Service Line	Name	Address	City	State	Zip
Hospital	Providence Newberg Medical Center	1001 Providence Dr	Newberg	Oregon	97132
Hospital	Providence Milwaukie Medical Center	10150 SE 32nd Ave	Milwaukie	Oregon	97222
Hospital	Providence Medford Medical Center	1111 Crater Lake Ave	Medford	Oregon	97504
Hospital	Providence Willamette Falls Medical Center	1500 Division St	Oregon City	Oregon	97045
Hospital	Providence Portland Medical Center	4805 NE Glisan St	Portland	Oregon	97213
Hospital	Providence Seaside Hospital	725 S Wahanna Rd	Seaside	Oregon	97138
Hospital	Providence Hood River Memorial Hospital	810 12th St, PO Box 149	Hood River	Oregon	97031
Hospital	Hoag Hospital Newport Beach	1 Hoag Dr	Newport Beach	California	92663
Hospital	Queen of the Valley Medical Center	1000 Trancas St	Napa	California	94558
Hospital	Providence St. Vincent Medical Center	9205 SW Barnes Rd	Portland	Oregon	97225
Hospital	St. Jude Medical Center	101 East Valencia Mesa Dr	Fullerton	California	92835
Hospital	Providence Sacred Heart Children's Hospital	101 West 8th Ave	Spokane	Washington	99204
Hospital	Providence Sacred Heart Medical Center	101 West 8th Ave	Spokane	Washington	99204
Hospital	St. Joseph Hospital, Orange	1100 West Stewart Dr	Orange	California	92868
Hospital	Santa Rosa Memorial Hospital	1165 Montgomery Dr	Santa Rosa	California	95405
Hospital	Providence Little Company of Mary Medical Center San Pedro	1300 W 7th St	San Pedro	California	90503
Hospital	Providence Holy Cross Medical Center	15031 Rinaldi St	Mission Hills	California	91345
Hospital	Hoag Hospital Irvine	16200 Sand Canyon Ave	Irvine	California	92618
Hospital	Hoag Orthopedic Institute	16250 Sand Canyon Ave	Irvine	California	92618
Hospital	Providence Regional Medical Center Everett	1700 13th St	Everett	Washington	98201
Hospital	St. Mary Medical Center	18300 Highway 18	Apple Valley	California	92307
Hospital	Providence Tarzana Medical Center	18321 Clark St	Tarzana	California	91356
Hospital	Covenant Hospital Levelland	1900 College Ave	Levelland	Texas	79336
Hospital	Providence Kodiak Island Medical Center	1915 East Rezanof Dr	Kodiak Island	Alaska	99615
Hospital	Providence Saint John's Health Center	2121 Santa Monica Blvd	Santa Monica	California	90404
Hospital	Swedish Medical Center, Edmonds Campus	21601 76th Ave W	Edmonds	Washington	98026
Hospital	Covenant Health Plainview	2601 Dimmit Rd	Plainview	Texas	79072
Hospital	St. Joseph Hospital, Eureka	2700 Dolbeer St	Eureka	California	95501
Hospital	Mission Hospital Mission Viejo	27700 Medical Center Rd	Mission Viejo	California	92691
Hospital	Mission Hospital Laguna Beach	31872 Coast Hwy	Laguna Beach	California	92651
Hospital	Providence Alaska Medical Center	3200 Providence Dr	Anchorage	Alaska	99508
Hospital	Redwood Memorial Hospital	3300 Renner Dr	Fortuna	California	95540
Hospital	Covenant Medical Center	3615 19th St	Lubbock	Texas	79410
Hospital	Covenant Specialty Hospital	3815 20th St	Lubbock	Texas	79410
Hospital	Petaluma Valley Hospital	400 N McDowell Blvd	Petaluma	California	94954
Hospital	Covenant Children's Hospital	4002 24th St	Lubbock	Texas	79410
Hospital	Providence St. Mary Medical Center	401 W Poplar St	Walla Walla	Washington	99362
Hospital	Providence Little Company of Mary Medical Center Torrance	4101 Torrance Blvd	Torrance	California	90503
Hospital	Providence St. Peter Hospital	413 Lilly Road NE	Olympia	Washington	98506
Hospital	Providence Seward Medical and Care Center	417 1st Ave	Seward	Alaska	99664
Hospital	Swedish Medical Center, Cherry Hill Campus	500 17th Ave	Seattle	Washington	98122
Hospital	Providence St. Joseph's Hospital	500 E Webster	Chewelah	Washington	99109
Hospital	Providence St. Patrick Hospital	500 W Broadway	Missoula	Montana	59802

Providence Acute Care Hospitals

Service Line	Name	Address	City	State	Zip
Hospital	Providence Saint Joseph Medical Center	501 S Buena Vista St	Burbank	California	91505
Hospital	Swedish Medical Center, Ballard Campus	5300 Tallman Ave NW	Seattle	Washington	98107
Hospital	Providence Holy Family Hospital	5633 N Lidgerwood St	Spokane	Washington	99208
Hospital	Providence St. Joseph Medical Center	6 13th Ave East	Polson	Montana	59860
Hospital	Swedish Medical Center, First Hill Campus	747 Broadway	Seattle	Washington	98122
Hospital	Swedish Medical Center, Issaquah Campus	751 NE Blakely Dr	Issaquah	Washington	98029
Hospital	Kadlec Regional Medical Center	888 Swift Blvd	Richland	Washington	99352
Hospital	Providence Valdez Medical Center	911 Meals Ave	Valdez	Alaska	99686
Hospital	Providence Centralia Hospital	914 S Scheuber Rd	Centralia	Washington	98531
Hospital	Providence Mount Carmel Hospital	982 E Columbia Ave	Colville	Washington	99114

Kindred Healthcare
Hospitals and Nursing Centers
As of: 3/15/2019

State	Type	Name	Street Address	City	Zip Code	License Contact Name	License Contact Address	Phone	Email
AZ	IRF	Dignity Health East Valley Rehabilitation Hospital	1515 West Chandler Boulevard	Chandler	85224-6141	Connie Belden	Arizona Division of Licensing Services, Bureau of Medical Facilities Licensing 150 North 18th Avenue, Suite 450, Phoenix, AZ 85007-3242	(602) 364-3030	connie.belden@azdhs.gov
CA	LTACH	Kindred Hospital - La Mirada	14900 E. Imperial Highway	La Mirada	90638-2172	Kathleen Keating	CDPH, CAU, Licensing & Certification Program P. O. Box 997377, MS 3207, Sacramento, CA 95899-7377	(916) 558-1723	kathleen.keating@cdph.ca.gov
CA	LTACH	Kindred Hospital - San Gabriel Valley	845 North Lark Ellen	West Covina	91791-1069	See Above			
CA	LTACH	Kindred Hospital - Santa Ana	1901 N. College Avenue	Santa Ana	92706-2334	See Above			
CA	LTACH	Kindred Hospital Baldwin Park	14148 E. Francisquito Avenue	Baldwin Park	91706-6120	See Above			
CA	LTACH	Kindred Hospital Riverside	2224 Medical Center Drive	Perris	92571-2638	See Above			
CA	LTACH	Kindred Hospital South Bay	1246 W. 155th Street	Gardena	90247-4011	See Above			
CA	LTACH	Kindred Hospital Rancho	10841 White Oak Avenue	Rancho Cucamonga	91730-3811	See Above			
CA	LTACH	Kindred Hospital - Brea	875 North Brea Boulevard	Brea	92821-2606	See Above			
CA	LTACH	Kindred Hospital - Ontario	550 North Monterey Avenue	Ontario	91764-3318	See Above			
CA	LTACH	Kindred Hospital - San Francisco Bay Area	2800 Benedict Drive	San Leandro	94577-6840	See Above			
CA	LTACH	Kindred Hospital Westminster	200 Hospital Circle	Westminster	92683-3910	See Above			
CA	LTACH	Kindred Hospital - San Diego	1940 El Cajon Boulevard	San Diego	92104-1005	See Above			
CA	LTACH	Kindred Hospital - Los Angeles	5525 West Slauson Avenue	Los Angeles	90056-1047	See Above			
CA	SAU	Kindred Hospital - Brea	875 North Brea Boulevard	Brea	92821-2606	See Above			
CO	LTACH	Kindred Hospital - Denver South	2525 South Downing St., 3rd Floor	Denver	80210-5817	Greg Wright, L&C Supervisor	4300 Cherry Creek Drive, South, Denver, CO 80222-1530	(303) 692-2813	greg.wright@state.co.us
CO	LTACH	Kindred Hospital - Denver	1920 High Street	Denver	80218-1213	See Above			
CO	LTACH	Kindred Hospital Aurora	700 Potomac St., 2nd Floor	Aurora	80011-6846	See Above			
FL	LTACH	Kindred Hospital - Bay Area - Tampa	4555 South Manhattan Avenue	Tampa	33611-2305	Jack Plagge	Agency for Health Care Administration 2727 Mahan Drive, Room 200, Tallahassee, FL 32308-5403	(850) 487-2717	plaggej@ahca.myflorida.com
FL	LTACH	Kindred Hospital - Bay Area St. Petersburg	3030 6th Street South	St. Petersburg	33705-3720	See Above			
FL	LTACH	Kindred Hospital - South Florida Ft. Lauderdale	1516 East Las Olas Boulevard	Ft. Lauderdale	33301-2346	See Above			
FL	LTACH	Kindred Hospital - South Florida - Coral Gables	5190 Southwest 8th Street	Coral Gables	33134-2476	See Above			
FL	LTACH	Kindred Hospital - South Florida - Hollywood	1859 Van Buren Street	Hollywood	33020-5127	See Above			
FL	LTACH	Kindred Hospital Ocala	1500 SW 1st Avenue, 5th Floor	Ocala	34471-6504	See Above			
FL	LTACH	Kindred Hospital The Palm Beaches	5555 W. Blue Heron Boulevard	Riviera Beach	33418-7813	See Above			
FL	LTACH	Kindred Hospital - North Florida	801 Oak Street	Green Cove Springs	32043-4317	See Above			
FL	LTACH	Kindred Hospital - Central Tampa	4801 North Howard Avenue	Tampa	33603-1411	See Above			
FL	LTACH	Kindred Hospital Melbourne	765 West Nasa Boulevard	Melbourne	32901-1815	See Above			
FL	SAU	Kindred Hospital - South Florida - Hollywood	1859 Van Buren Street	Hollywood	33020-5127	See Above			
GA	LTACH	Kindred Hospital Rome	320 Turner McCall Blvd.	Rome	30165-5621	Ms. Bola Ansa, Director, Acute Care Division	Healthcare Facility Regulation 2 Peachtree Street NW, Suite 31-447, Atlanta GA 30303	(404) 657-5850	abansa@dch.ga.gov
IA	IRF	Mercy Rehabilitation Hospital	1401 Campus Drive	Clive	50325-6500	Patrice Fagen, Assistant Division Administrator	Health Services Division Lucas State Office Building, Des Moines, IA 50319-2079	(515) 281-4245	patrice.fagen@dia.iowa.gov
IL	LTACH	Kindred - Chicago - Central Hospital	4058 West Melrose Street	Chicago	60641-4794	Karen Senger, Division Chief	Illinois Dept of Public Health Division of Health Care Facilities and Programs 525 W. Jefferson St., 4th Flr, Springfield, IL 62761	(217) 782-0381	karen.senger@illinois.gov
IL	LTACH	Kindred - Chicago - Lakeshore	6130 North Sheridan Road	Chicago	60660-2830	See Above			
IL	LTACH	Kindred Hospital - Chicago (Northlake Campus)	365 East North Avenue	Northlake	60164-2628	See Above			
IL	LTACH	Kindred Hospital - Chicago (North Campus)	2544 West Montrose Avenue	Chicago	60618-1537	See Above			
IL	LTACH	Kindred Hospital - Sycamore	225 Edward Street	Sycamore	60178-2137	See Above			
IL	LTACH	Kindred Hospital Peoria	500 West Romeo B. Garrett Avenue	Peoria	61605-2301	See Above			
IN	IRF	Community Health Network Rehabilitation Hospital	7343 Clearvista Drive	Indianapolis	46256-4602	Jennifer Hembree	Indiana State Dept. of Health Acute Care, 4th Floor, 2 N. Meridian St, Indianapolis, IN 46204	(317) 232-3095	jhembree@isdh.in.gov
IN	IRF	Community Health Network Rehabilitation Hospital South	607 Greenwood Springs Drive	Greenwood	46143-6377	See Above			
IN	LTACH	Kindred Hospital Indianapolis North	8060 Knue Road	Indianapolis	46250-1976	See Above			
IN	LTACH	Kindred Hospital - Indianapolis	1700 West 10th Street	Indianapolis	46222-3802	See Above			
IN	LTACH	Kindred Hospital Northwest Indiana	5454 Hohman Avenue, 5th Fl.	Hammond	46320-1931	See Above			

Kindred Healthcare
Hospitals and Nursing Centers
As of: 3/15/2019

State	Type	Name	Street Address	City	Zip Code	License Contact Name	License Contact Address	Phone	Email	
KY	LTACH	Kindred Hospital - Louisville	1313 St. Anthony Place	Louisville	40204-1740	Jami Biggs or Joshua Gaddie	Division of Health Care 275 E. Main Street, 5E- A, Frankfort, KY 40621	(502) 564-7963, ext. 3301 or ext. 3346	jami.biggs@ky.gov or joshua.gaddie@ky.gov	
KY	LTACH	Kindred Hospital - Louisville at Jewish Hospital	200 Abraham Flexner Way, 2nd Fl Frazier Inst.	Louisville	40202-2878	See Above				
KY	SAU	Kindred Hospital - Louisville	1313 St. Anthony Place	Louisville	40204-1740	See Above				
MO	LTACH	Kindred Hospital - St. Louis	4930 Lindell Boulevard	St. Louis	63108-1510	Sarah Burch	Bureau of Hospital Standards	Missouri Department of Health and Senior Services, P. O. Box 570, Jefferson City, MO 65102-0570	(573) 751-6306	sarah.burch@health.mo.gov
MO	LTACH	Kindred Hospital - St. Louis - St. Anthony's	10018 Kennerly Road, 3rd Floor, Hyland Bldg. B	St. Louis	631282106	See Above				
MO	IRF	Mercy Rehabilitation Hospital Springfield	5904 S. Southwood Road	Springfield	65804-5234	See Above				
MO	IRF	Mercy Rehabilitation Hospital St. Louis	14561 North Outer Forty Road	Chesterfield	63017-5703	See Above				
MO	IRF	St. Luke's Rehabilitation Hospital	14709 Olive Blvd.	Chesterfield	63017-2221	See Above				
MO	LTACH	Kindred Hospital Northland	500 NW 68th Street	Kansas City	64118-2455	See Above				
NC	LTACH	Kindred Hospital - Greensboro	2401 Southside Boulevard	Greensboro	27406-3311	Azzie Conley, Chief	NC Dept of Health and Human Services	Acute and Home Care Licensure and Certification Section, 2712 Mail Service Center, Raleigh, NC 27699-2712	(919) 855-4620	DHRS_homecare@dhhs.nc.gov
NC	SAU	Kindred Hospital - Greensboro	2401 Southside Boulevard	Greensboro	27406-3311	See Above				
NJ	LTACH	Kindred Hospital New Jersey - Morris County	400 W. Blackwell Street	Dover	07801-2525		NJ Department of Health.	Department of Health P. O. Box 358 Trenton, NJ 08625-0358	(609) 292-6552	
NJ	LTACH	Kindred Hospital New Jersey - Rahway	865 Stone Street, 4th Floor	Rahway	07065-2742	See Above				
NJ	LTACH	Kindred Hospital New Jersey - Wayne	224 Hamburg Turnpike, 6th Floor	Wayne	07470-2168	See Above				
NM	LTACH	Kindred Hospital - Albuquerque	700 High Street, N.E.	Albuquerque	87102-2565	John Dominguez	NM Department of Health.	Survey Processing Section, Program Operations Bureau 2040 S. Pacheco, Second Floor, Room 242 Santa Fe, NM	(505) 476-9052	john.dominguez@state.nm.us
NV	LTACH	Kindred Hospital - Las Vegas (Sahara Campus)	5110 West Sahara Avenue	Las Vegas	89146-3406	Paul Shubert, Health Facilities Inspection Manager	NV Department of Health & Human Services	Division of Public and Behavioral Health Bureau of Health Care Quality and Compliance 727 Fairview Drive, Suite E Carson City, NV 89701	(775) 684-1030	pshubert@health.nv.gov
NV	LTACH	Kindred Hospital - Las Vegas at St. Rose Dominican Hospital - Rose de Lima	102 E. Lake Mead Parkway, Third Floor	Henderson	89015-5575	See Above				
NV	LTACH	Kindred Hospital Las Vegas - Flamingo Campus	2250 East Flamingo Road	Las Vegas	89119-5170	See Above				
NV	SAU No Ct.	Kindred Hospital Las Vegas - Flamingo Campus	2250 East Flamingo Road	Las Vegas	89119-5170	See Above				
NV	SNF	Kindred Transitional Care and Rehabilitation- Spring Valley	5650 S. Rainbow Boulevard	Las Vegas	89118-1808	See Above				
OH	IRF	University Hospitals Rehabilitation Hospital	23333 Harvard Road	Beachwood	44122-6232	Debra Walsh	Ohio Department of Health	Health Services Policy Supervisor, ODH, 246 N. High St Columbus, OH 43231	(614) 466-2306	debra.walsh@odh.ohio.gov
OH	IRF	University Hospitals Avon Rehabilitation Hospital	37900 Chester Road	Avon	44011-1044	See Above				
OH	LTACH	Kindred Hospital - Dayton	707 S. Edwin C. Moses	Dayton	45417-3462	See Above				
OH	LTACH	Kindred Hospital Lima	730 West Market Street	Lima	45801-4602	See Above				
OK	IRF	Mercy Rehabilitation Hospital Oklahoma City	5401 W. Memorial Road	Oklahoma City	73142-2026	Terri Cook, Admin. Programs Mgr.	Oklahoma State Dept. of Health	Facilities Services Division, Medical Facilities Service 1000 NE 10th Street Oklahoma City, OK 73117	(405) 271-6576	terrid@health.ok.gov

Kindred Healthcare
Hospitals and Nursing Centers
As of: 3/15/2019

State	Type	Name	Street Address	City	Zip Code	License Contact Name	License Contact Address	Phone	Email
PA	LTACH	Kindred Hospital - Philadelphia	6129 Palmetto Street	Philadelphia	19111-5729	Garrison Gladfelter	Pennsylvania Dept of Health Division of Acute and Ambulatory Care Room 532 Health and Welfare 625 Forster Street Harrisburg, PA 17120	(717) 783-8980	ggladfelte@pa.gov
PA	LTACH	Kindred Hospital Philadelphia - Havertown	2000 Old West Chester Pike	Havertown	19083-2712	See Above			
PA	IRF	Lancaster Rehabilitation Hospital	675 Good Drive	Lancaster	17601-2426	See Above			
PA	IRF	St. Mary Rehabilitation Hospital	1208 Langhorne Newtown Road	Langhorne	19047-1234	See Above			
PA	LTACH	Kindred Hospital South Philadelphia	1930 South Broad Street, Unit #12	Philadelphia	19145-2328	See Above			
TN	IRF	Baptist Memorial Rehabilitation Hospital	1240 South Germantown Road	Germantown	38138-2226	Eddie Stewart, Health Facilities Program Manager	Division of Health Licensure and Regulation Office of Health Care Facilities, 665 Mainstream Drive, Second Floor Nashville, TN 37243	(615) 741-7188	eddie.j.stewart@tn.gov
TN	LTACH	Kindred Hospital - Chattanooga	709 Walnut Street	Chattanooga	37402-1916	See Above			
TX	LTACH	Kindred Hospital - Tarrant County (Arlington Campus)	1000 North Cooper Street	Arlington	76011-5540	Angela Arthur, License & Permit Specialist III	Health Facility Licensing Group Regulatory Licensing Unit Health and Human Services 1100 W. 49th Street, Austin, TX 78756	(512) 458-7111	angela.arthur@hhsc.state.tx.us
TX	LTACH	Kindred Hospital - Tarrant County (Fort Worth Southwest Campus)	7800 Oakmont Boulevard	Fort Worth	76132-4203	See Above			
TX	LTACH	Kindred Hospital Houston NW	11297 Fallbrook Drive	Houston	77065-4230	See Above			
TX	LTACH	Kindred Hospital Bay Area	4801 East Sam Houston Parkway South	Pasadena	77505-3955	See Above			
TX	LTACH	Kindred Hospital Tomball	505 Graham Drive	Tomball	77375-3368	See Above			
TX	LTACH	Kindred Hospital Spring	205 Hollow Tree Lane	Houston	77090-2801	See Above			
TX	LTACH	Kindred Hospital The Heights	1800 West 26th Street	Houston	77008-1450	See Above			
TX	IRF	Methodist Rehabilitation Hospital	3020 W. Wheatland Road	Dallas	75237-3537	See Above			
TX	IRF	Texas Rehabilitation Hospital of Arlington	900 West Arbrook Blvd.	Arlington	76015-4314	See Above			
TX	IRF	Texas Rehabilitation Hospital of Fort Worth	425 Alabama Avenue	Fort Worth	76104-1022	See Above			
TX	IRF	Kindred Rehabilitation Hospital Northeast Houston	18839 McKay Boulevard	Humble	77338-5712	See Above			
TX	IRF	Kindred Rehabilitation Hospital Clear Lake	655 E. Medical Center Blvd.	Webster	77598-4328	See Above			
TX	IRF	Central Texas Rehabilitation Hospital	700 West 45th Street	Austin	78751-2800	See Above			
TX	LTACH	Kindred Hospital - San Antonio Central	111 Dallas Street, 4th Floor	San Antonio	78205-1201	See Above			
TX	LTACH	Kindred Hospital - Dallas	9525 Greenville Avenue	Dallas	75243-4116	See Above			
TX	LTACH	Kindred Hospital - San Antonio	3636 Medical Drive	San Antonio	78229-2183	See Above			
TX	LTACH	Kindred Hospital - Mansfield	1802 Highway 157 North	Mansfield	76063-3923	See Above			
TX	LTACH	Kindred Hospital - Fort Worth	815 Eighth Avenue	Fort Worth	76104-2609	See Above			
TX	LTACH	Kindred Hospital Houston Medical Center	6441 Main Street	Houston	77030-1502	See Above			
TX	LTACH	Kindred Hospital Sugar Land	1550 First Colony Blvd.	Sugar Land	77479-4000	See Above			
TX	LTACH	Kindred Hospital Dallas Central	8050 Meadow Road	Dallas	75231-3406	See Above			
TX	LTACH	Kindred Hospital El Paso	1740 Curie Drive	El Paso	79902-2901	See Above			
TX	LTACH	Kindred Hospital Clear Lake	350 Blossom Street	Webster	77598-4206	See Above			
WA	LTACH	Kindred Hospital Seattle - Northgate	10631 8th Avenue NE	Seattle	98125-7213	Crissa Hanson	Washington State Department of Health 111 Israel Rd, SE, Turnwater, WA 98501	(360) 236-4735	crissa.hanson@doh.wa.gov
WA	LTACH	Kindred Hospital Seattle - First Hill	1334 Terry Avenue	Seattle	98101-2747	See Above			
WA	IRF	CHI Franciscan Rehabilitation Hospital	815 S. Vassault Street	Tacoma	98465-2008	See Above			
WI	IRF	UW Health Rehabilitation Hospital	5115 N. Biltmore Lane	Madison	53718-2161	Angela Mack Health Services Management Section Chief	Bureau of Health Services Division of Quality Assurance 1 West Wilson Street, Room 455 Madison, WI 53701-2969	(608) 266-7485	angela.mack@dhs.wisconsin.gov
WI	IRF	Rehabilitation Hospital of Wisconsin	1625 Coldwater Creek Drive	Waukesha	53188-8028	See Above			

Kindred Healthcare
 Rehabilitation Agencies
 As of: 3/15/2019

State	D/B/A Name	Name of Facility (may be located inside another business)	Address	City	Zip	Medicare Provider #	Medicaid Provider #	License Contact Name	License Contact Address	Phone	Email	
AL	RehabCare	RehabCare Agency AL	235 Inverness Center Drive	Hoover	35242-4805	01-6556	N/A	Kristen Norman, Licenseure Director	State of Alabama Department of Public Health	The RSA Tower, 201 Monroe St. Montgomery, AL 36104	(334) 206- 5234	Kristen.Norman@adph.state.al.us or Tara.Harriel@adph.state.al.us
CA	RehabCare	RehabCare Agency S CA (Laguna Hills)	24422 Avenida de la Carlota, Ste 165	Laguna Hills	92653-3636	55-6581	N/A	N/A				
CA	RehabCare	RehabCare Agency N CA (Pleasant Hill)	399 Taylor Blvd, Suite 208	Pleasant Hill	94523-2287	55-6585	N/A	N/A				
CO	RehabCare	RehabCare Agency CO	12567 West Cedar Drive, Suite 120	Lakewood	80228-2039	06-6626	9000152213	N/A				
CO	RehabCare	Mullen Home - Little Sisters of the Poor	3629 W. 29th Avenue	Denver	80211-3611	06-6626	9000161913	N/A				
CO	RehabCare	Balfour at Riverfront Park	1590 Little Raven Street	Denver	80202-6182	06-6626	N/A	N/A				
CO	RehabCare	Springbrooke	6800 Leetsdale Drive	Denver	80224-1588	06-6626	9000165591	N/A				
CO	RehabCare	Balfour Retirement	1855 Plaza Drive	Louisville	80027-2325	06-6626	9000161740	N/A				
FL	Bodymax Physical Therapy	Bodymax Physical Therapy c/o The Cloisters of Deland	400 East Howry Avenue	Deland	32724-5400	68-6629	N/A	N/A				
FL	RehabCare	Arbor Terrace at Citrus Park	13810 Sheldon Road	Tampa	33626-3679	68-6927	024422900	N/A				
FL	RehabCare	Bob Hope Village	1200 Hawthorne House Drive	Shalimar	32579-1168	68-6949	023589900	N/A				
IL	RehabCare	RehabCare Agency IL	15 Bronze Pointe, Suite B	Swansea	62226-1197	14-6723	1437323367	N/A				
IL	RehabCare	The Fountains - Shiloh	1201 Hartman Lane	Shiloh	62221-8402	14-6723	N/A	N/A				
IL	RehabCare	The Fountains of Troy	39 Dorothy Drive	Troy	62294-1389	14-6723	N/A	N/A				
IL	RehabCare	Fountains of Godfrey	1000 Airport Road	Godfrey	62035-2929	14-6723	N/A	N/A				
IL	RehabCare	Fountains of Granite City	3450 Village Lane, Apt. 112	Granite City	62040-7700	14-6723	N/A	N/A				
IL	RehabCare	Apt. Com. Lady of the Shows	726 Community Drive	Belleville	62223-1026	14-6723	N/A	N/A				
IL	RehabCare	Garden Place of Columbia	480DD Road	Columbia	62236-3837	14-6723	N/A	N/A				
IL	RehabCare	United Methodist Village Godfrey	5201 Asbury Avenue	Godfrey	62035-4807	14-6723	N/A	N/A				
IL	RehabCare	IL Rehab Agency Algonquin	212 Eastgate Court	Algonquin	60102-3003	14-6752	1871037861	N/A				
IN	Bedford Outpatient Therapy Specialists	Bedford Outpatient Therapy Specialists	2137 16th Street	Bedford	47421-3003	15-6640	201216430A	N/A				
KS	RehabCare	RehabCare Agency KS	15301 West 87th Street, Suite 200	Lenexa	66219-1479	17-6552	N/A	N/A				
KY	RehabCare	RehabCare Agency KY	108 Diagnostic Drive, Suite C	Frankfort	40601-6556	18-6696	7100487970	N/A				
KY	RehabCare	Provision Living at Beaumont Centre	1165 Monarch Street	Lexington	40513-1899	18-6696		N/A				
LA	The Therapy Group, LLC	The Therapy Group, LLC	7843 Park Avenue	Houma	70364-3112	19-6559	1930598	N/A				
MA	RehabCare	RehabCare Agency MA (@ KTR&C-Avery)	100 West Street, Suite 3B	Needham	02494-1319	22-6548	N/A	Pearlina Mills, Licenseure Coordinator	Massachusetts Department of Public Health	Care Facility Licenseure and Certification, 99 Chauncy Street, 11th Floor, Boston, MA 02111	(617) 753- 8124	Pearlina.Mills@state.ma.us
MD	Peoplefirst Rehabilitation Services	Peoplefirst Rehabilitation Services (located @ Mercy Ridge Retirement Community)	2525 Pot Springs Road	Timonium	21093-2778	21-6681	416173400	N/A				
MD	Peoplefirst Rehabilitation Services	Brookdale Olney	2611 Olney Sandy Springs Road	Olney	20832-1604	21-6681	416173400	N/A				
MN	RehabCare	RehabCare Agency MN	3390 Annapolis Lane N. (eff. 3/1/18)	Plymouth	55447-5379	24-6509	333993000	Lara Ann Mazzitello	Minnesota Department of Health	Home Care and Assisted Living Program Health Regulation Division, 85 East Seventh Place, Suite 220, St. Paul, MN 55164- 0900	(651) 201- 5273	Lari.Mazzitello@state.mn.us or health.homecare@state.mn.us
MO	RehabCare	RehabCare Agency MO	439 S. Kirkwood Rd, Suite 200	Kirkwood	63122-6169	26-6554	573258407	N/A				
MO	RehabCare	Autumn View Gardens Ellisville	16219 Autumn View Terrace	Ellisville	63011-4743	26-6554	573258407	N/A				
MO	RehabCare	Crab Apple Village Senior Estates	214 Hartman Place, Suite 100	St. Clair	63077-2457	26-6554	573258407	N/A				
MO	RehabCare	Little Sisters of the Poor	3225 N. Florissant Ave.	St. Louis	63107-3521	26-6554	573258407	N/A				
MO	RehabCare	Mother of Good Counsel	6825 Natural Bridge	St. Louis	63121-5314	26-6554	573258407	N/A				
MO	RehabCare	Fountains of West County	15826 Clayton Road	Ellisville	63011-2240	26-6554	573258407	N/A				
MO	RehabCare	Primrose Retirement Com. Jeff. City	1214 Freedom Boulevard	Jefferson City	65109-0082	26-6676	N/A	N/A				
NC	RehabCare	RehabCare Agency NC	932 Hendersonville Road, Suite 104	Asheville	28803-1761	Pending		Azzie Conley, Director	North Carolina Department of Health and Human Services	Division Health Service Regulation, Licenseure/Certification /Acute/Home Care Section 1205 Umstead Drive, Raleigh, NC 27603	(919) 855- 4620	Azzie.Conley@dhhs.nc.gov or Nancy.Joyce@dhhs.nc.gov
NC	RehabCare	RehabCare Agency NC	29 Highbridge Crossing	Asheville	28803-3496	34-6520	Pending	See above				
NC	RehabCare	Brooks Howell Home	266 Merrimon Avenue	Asheville	28801-1218	34-6520	N/A	See above				

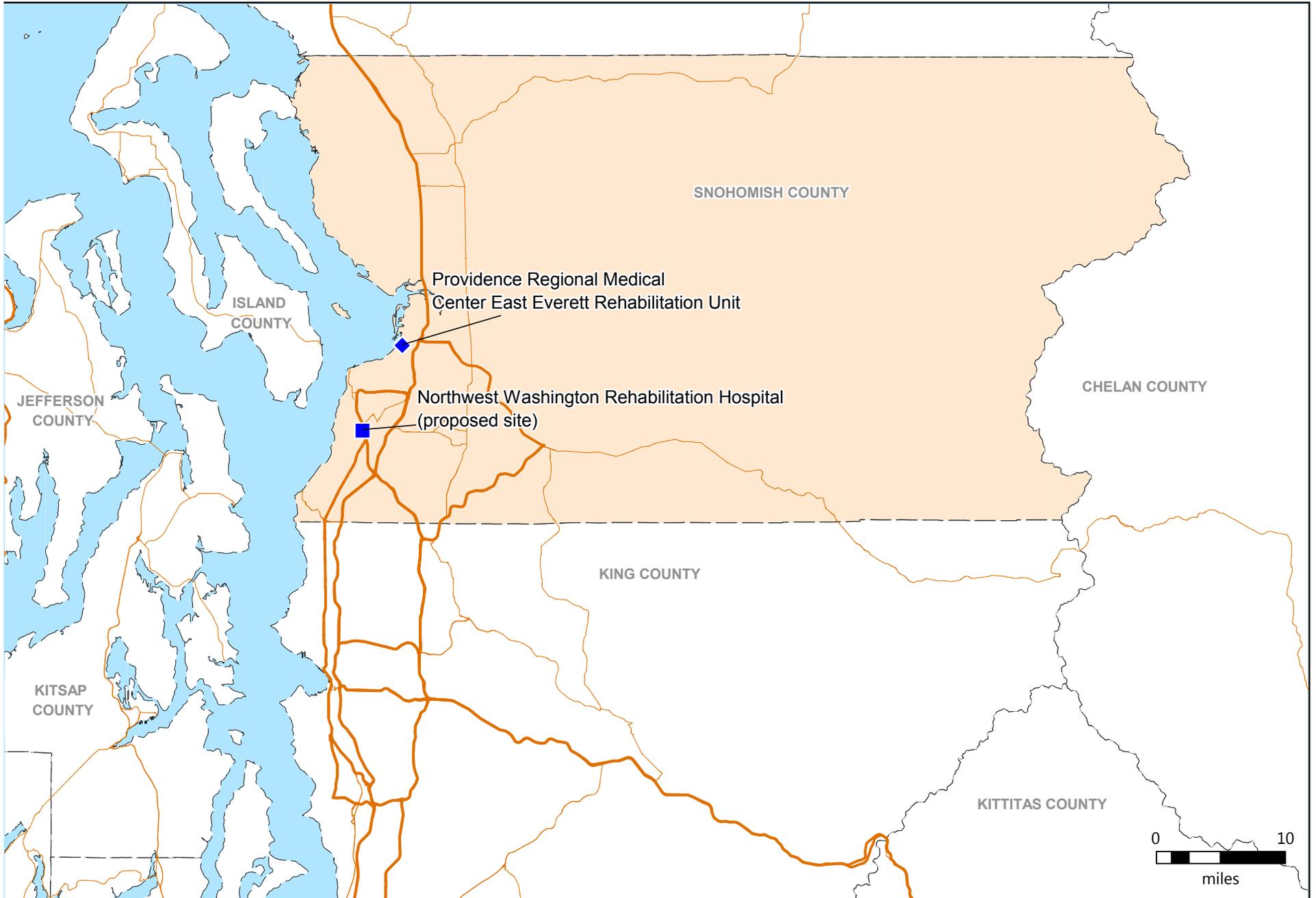
Kindred Healthcare
 Rehabilitation Agencies
 As of: 3/15/2019

State	D/B/A Name	Name of Facility (may be located inside another business)	Address	City	Zip	Medicare Provider #	Medicaid Provider #	License Contact Name	License Contact Address	Phone	Email	
OH	RehabCare	RehabCare Agency OH	3864 Center Road, Ste B1	Brunswick	44212-6601	36-6761	Pending	N/A				
OH	RehabCare	Vista Springs Greenbriar	8668 Day Drive	Parma	44129-5692	36-6761	Pending	N/A				
OH	RehabCare	Danberry Senior Living @ Broadview Heights	9500 Broadview Road	Broadview Heights	44147-2302	36-6761	Pending	N/A				
OK	RehabCare	RehabCare Agency OK	4301 NW 63rd, Ste 304	Oklahoma City	73116-1504	37-6588	200100810A	Terri Cook	Oklahoma State Department of Health	Protective Health Services, Medical Facilities Services, P. O. Box 268823, Oklahoma City, OK 73126-8823.	(405) 271-6576 or (405) 271-6576, ext. 5730.	TerriD@health.ok.gov or MichelleSteele@health.ok.gov
OK	RehabCare	Ten Oaks at Merrill Gardens	3610 SE Huntington Circle	Lawton	73501-8445	37-6588	200100810A	See above				
PA	RehabCare	RehabCare Agency PA	1513 Scalp Avenue, Unit #260	Johnstown	15904-3332	39-6608	N/A	N/A				
SC	RehabCare	RehabCare Agency SC	421 Squire Pope Road	Hilton Head Island	29926-1229	42-6648		N/A				
TN	RehabCare	RehabCare Agency TN	2851 Stage Village Cove, Suite 6	Bartlett	38134-4683	44-6564	Q025161	N/A				
TN	RehabCare	RehabCare @ Ashland City	2035 Vantage Pointe Road	Ashland C ity	37015-4093	44-6717	Q034161	N/A				
TN	RehabCare	RehabCare @ Chattanooga	825 Runyan Drive	Chattanooga	37405-1225	44-6721	Pending	N/A				
TX	RehabCare	RehabCare Agency TX	5720 LBJ Freeway, Ste 190	Dallas	75240-6366	45-6662	184688301	Texas Health and Human Services Commission	P. O. Box 13247	Austin, TX 78711-3247	(512) 438-2630	
TX	RehabCare	Isle at Watermere	101 Watermere Drive	Southlake	76092-8116	45-6662	184688301	or				
TX	RehabCare	Isle at Watercrest of Mansfield	200 East Debbie Lane	Mansfield	76063-9211	45-6662	184688301	Executive Council of Physical Therapy and Occupational Therapy Examiners	333 Guadalupe, Suite 2-510	Austin, TX 78701-3942	(512) 305-6951	
TX	RehabCare	James L. West Alzheimer Center	1111 Summitt Avenue	Fort Worth	76102-3425	45-6662	184688301	See Above				
TX	RehabCare	RehabCare @ Isle at Kingwood	24025 Kingwood Place Drive	Kingwood	77339-3862	67-6740	Pending	See Above				
TX	RehabCare	RehabCare @ Round Rock	2851 Joe DiMaggio Boulevard, Bldg. 6,	Round Rock	78665-3928	67-6743	Pending	See Above				
TX	RehabCare	RehabCare @ Raider Ranch	6806 43rd Street	Lubbock	79407-1947	67-6747	Pending	See Above				
TX	RehabCare	RehabCare @ Isle at Watercrest Dominion	6906 Heuermann Road	San Antonio	78256-2619	67-6746	Pending	See Above				
VA	Peoplefirst Rehabilitation Services	Peoplefirst Virginia, LLC	112 Oaktree Boulevard	Christiansburg	24073-1488	49-6707	N/A	N/A				
VA	Peoplefirst Rehabilitation Services	VA Rehab Agency @ English Meadows	1140 West Main Street	Christiansburg	24073-4222	49-6707	N/A	N/A				
WA	RehabCare	RehabCare Agency WA	8105 166th Avenue NE, Suite 105	Redmond	98052-3999	50-6611	1063954972	N/A				
WI	RehabCare	RehabCare Agency WI	3939 S. 92nd Street	Greenfield	53228-2140	52-6538	41814900	N/A				

Exhibit 6

Snohomish County Planning Area Definition and Map

Northwest Washington Rehabilitation Hospital Snohomish County Service Area



**Snohomish County Planning Area
List of Zip Codes**

Zip	City
98012	BOTHELL
98020	EDMONDS
98021	BOTHELL
98026	EDMONDS
98036	LYNNWOOD
98037	LYNNWOOD
98043	MOUNTLAKE TERRACE
98046	LYNNWOOD (PO BOX)
98082	MILL CREEK (PO BOX)
98087	LYNNWOOD
98201	EVERETT
98203	EVERETT
98204	EVERETT
98205	EVERETT
98206	EVERETT (PO BOX)
98207	EVERETT (NAVAL STATION EVERETT)
98208	EVERETT
98213	EVERETT (PO BOX)
98223	ARLINGTON
98241	DARRINGTON
98251	GOLD BAR
98252	GRANITE FALLS
98256	INDEX
98258	LAKE STEVENS
98259	NORTH LAKEWOOD (PO BOX)
98270	MARYSVILLE
98271	MARYSVILLE
98272	MONROE
98275	MUKILTEO
98287	SILVANA (PO BOX)
98290	SNOHOMISH
98291	SNOHOMISH (PO BOX)
98292	STANWOOD
98293	STARTUP (PO BOX)
98294	SULTAN
98296	SNOHOMISH

Exhibit 7

Kindred Funding Letter



April 24, 2019

Janis Sigman, Manager
Certificate of Need Program
Washington State Department of Health
111 Israel Road SE
Olympia, WA 98504-7852

RE: Northwest Washington Rehabilitation Hospital, LLC Capital Commitment

Dear Ms. Sigman:

Providence Health & Services ("Providence") and Kindred Healthcare, LLC. ("Kindred"), through their affiliates, intend to develop a free-standing inpatient rehabilitation facility (the "IRF") in Snohomish County, Washington through a joint venture (the "JV") between the two parties.

The purpose of this letter is to confirm to the Washington State Department of Health Certificate of Need Program that it is Kindred's intention to contribute to the capital of the JV certain items of equipment suitable for use in the IRF's operations with a fair market value of Three Million Dollars (\$3,000,000).

Please let me know if you need any additional information regarding this matter.

Sincerely,

A handwritten signature in black ink, appearing to read "Jeffrey R. Stodghill".

Jeffrey R. Stodghill
Vice President and Corporate Counsel

Exhibit 8

Site Purchase Agreement and Kindred Letter to NWRH



Dedicated to Hope, Healing and Recovery

March 25, 2019

Northwest Washington Rehabilitation Hospital, LLC
C/o John C. Haralson
113 Seaboard Lane, Ste B201
Franklin, TN 37067

RE: Letter of Intent to Transfer Land

Dear Mr. Haralson:

As you know, Kindred Healthcare Operating, LLC ("Kindred") has entered into Real Estate Purchase and Sale Agreement dated January 14, 2019 (the "Agreement") with Tree Owl Properties LLC to purchase those parcels of land commonly known as 12911 Beverly Park Road, in Lynnwood, Washington, which are more particularly described in Exhibit A attached hereto (the "Property").

Kindred currently has plans to acquire the Property and assign its interest in the Agreement to a real estate development company who will acquire the Property, construct a rehabilitation hospital thereon, and then lease the Property to Northwest Washington Rehabilitation Hospital, LLC (the "Rehabilitation Hospital").

If you have any questions about this matter, please contact me at 502-596-7556.

Very truly yours,

Kindred Healthcare Operating, LLC

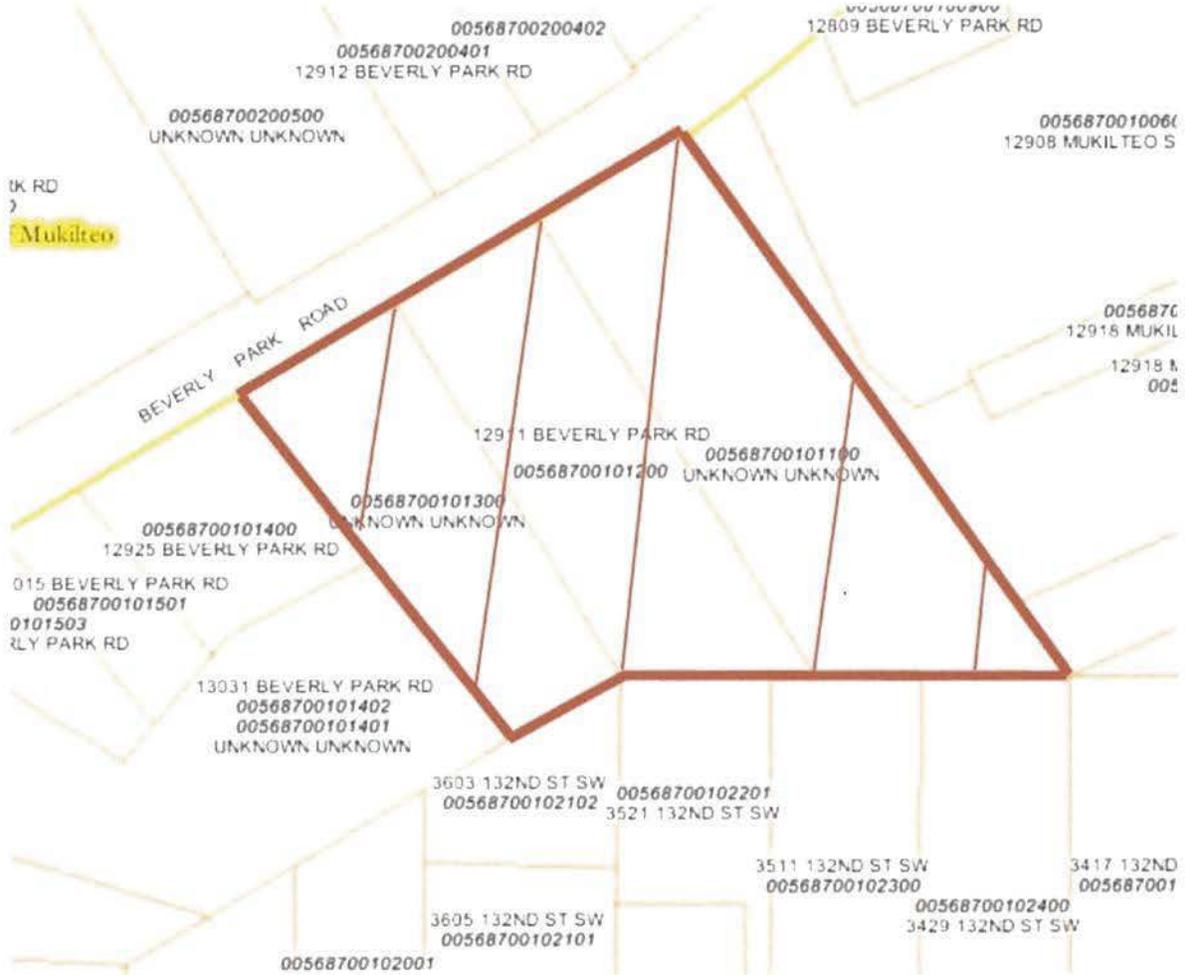
A handwritten signature in blue ink, appearing to read "Cristina E. O'Brien". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Cristina E. O'Brien
Vice President, Real Estate Counsel

EXHIBIT A

DESCRIPTION OF THE PROPERTY

Those parcels of land that are cross-hatched below, which are more particularly described as the following Snohomish County, Washington tax parcels: 00568700101100; 00568700101200; and 00568700101300.



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Purchase & Sale Agreement
Rev. 1/2011
Page 1 of 17

**COMMERCIAL & INVESTMENT REAL ESTATE
PURCHASE & SALE AGREEMENT**

*This has been prepared for submission to your attorney for review and approval
prior to signing. No representation is made by licensee as to its sufficiency or tax consequences*

Reference Date: January 14, 2019

Kindred Healthcare Operating, LLC, a Delaware limited liability company ("Buyer") agrees to buy and Tree Owl Properties LLC, ("Seller") agrees to sell, on the following terms, the commercial real estate and all improvements thereon (collectively, the "Property") commonly known as 12911 Beverly Park Road, Lynnwood, Snohomish County, Washington, and more particularly described on attached Exhibit A. The Reference Date above is intended to be used to reference this Agreement and is not the date of "Mutual Acceptance," which is defined in Section 23.

1. **PURCHASE PRICE.** The purchase price is Two Million Seven Hundred Thousand and No/100 Dollars (\$2,700,000.00) payable as defined below:

- All cash at closing with no financing contingency.
- All cash at closing contingent on new financing in accordance with the Financing Addendum (attach CBA Form PS_FIN).
- \$ _____ OR ___ % of the purchase price in cash at closing with the balance of the purchase price paid as follows (**check one or both, as applicable**): Buyer's assumption of the outstanding principal balance as of the Closing Date of a first lien note and deed of trust (or mortgage), or real estate contract, in accordance with the Financing Addendum (attach CBA Form PS_FIN); Buyer's delivery at closing of a promissory note for the balance of the purchase price, secured by a deed of trust encumbering the Property, in accordance with the Financing Addendum (attach CBA Form PS_FIN).
- Other: _____.

2. **EARNEST MONEY.** The earnest money in the amount of \$25,000.00 shall be in the form of Cash and an additional \$25,000 in the form of a Personal check Promissory note (attached CBA Form EMN) Other: _____ The earnest money shall be held by Selling Firm Closing Agent. Selling Broker may, however, transfer the earnest money to Closing Agent. Buyer shall deliver the earnest money no later than:

INITIALS: Buyer CK Date 1/21/2019 Seller KRC Date 1-17-19
 Buyer _____ Date _____ Seller C.J. Date 1/17/19
 Seller KRC Date: 01/17/19

- Twenty (20) days after Mutual Acceptance.
- On the last day of the Feasibility Period defined in Section 5 below.
- Other: _____.

Buyer agrees to pay financing and purchase costs incurred by Buyer. Unless otherwise provided in this Agreement, the earnest money, and any additional earnest money, shall be applicable to the purchase price.

3. EXHIBITS AND ADDENDA. The following Exhibits and Addenda are made a part of this Agreement:

- Exhibit A - Legal Description
- Earnest Money Promissory Note, CBA Form EMN
- Promissory Note, LPB Form No. 28A
- Short Form Deed of Trust, LPB Form No. 20
- Deed of Trust Rider, CBA Form DTR
- Utility Charges Addendum, CBA Form UA
- FIRPTA Certification, CBA Form 22E
- Assignment and Assumption, CBA Form PS-AS
- Addendum/Amendment, CBA Form PSA
- Back-Up Addendum, CBA Form BU-A
- Vacant Land Addendum, CBA Form VLA
- Financing Addendum, CBA Form PS_FIN
- Tenant Estoppel Certificate, CBA Form PS_TEC
- Defeasance Addendum, CBA Form PS_D
- Other _____

4. SELLER'S UNDERLYING FINANCING. Unless Buyer is assuming Seller's underlying financing, Seller shall be responsible for confirming the existing underlying financing is not subject to any "lock out" or similar covenant which would prevent the lender's lien from being released at closing. In addition, Seller shall provide Buyer notice prior to the end of the Feasibility Period if Seller is required to substitute securities for the Property as collateral for the underlying financing (known as "defeasance"). If Seller provides this notice of defeasance to Buyer, then the parties shall close the transaction in accordance with the process described in CBA Form PS_D or any different process identified in Seller's defeasance notice to Buyer.

INITIALS: Buyer CH Date 1/21/2019 Seller KRC Date 1-17-19
 Buyer _____ Date _____ Seller cg Date 1/17/19
 Seller KAZ Date: 01/17/19

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Purchase & Sale Agreement
Rev. 1/2011
Page 3 of 17

5. **FEASIBILITY CONTINGENCY.** Buyer's obligations under this Agreement are conditioned upon Buyer's satisfaction in Buyer's sole discretion, concerning all aspects of the Property, including its physical condition; the presence of or absence of any hazardous substances; the contracts and leases affecting the property; the potential financial performance of the Property; the availability of government permits and approvals; and the feasibility of the Property for Buyer's intended purpose. This Agreement shall terminate and Buyer shall receive a refund of the earnest money unless Buyer gives written notice to Seller within 120 days, or as such time may be extended as set forth below (the "Feasibility Period") of Mutual Acceptance stating that this condition is satisfied. If such notice is timely given, the feasibility contingency stated in this Section 5 shall be deemed to be satisfied. Buyer has the option to extend the Feasibility Period for up to two (2) periods of thirty (30) days each. Buyer shall deposit additional earnest money in the amount of \$10,000 ("Extension Payment") for each extension period in the same manner as set forth above for the original earnest money; provided, however, each Extension Payment shall be made immediately available to Seller and shall be non-refundable in the event that this Agreement is terminated. Such additional earnest money shall be due within five (5) days from Buyer's notice(s) to Seller of Buyer's election to extend the Feasibility Period. To the extent that Buyer needs to secure any regulatory approvals, including, without limitation, planning and zoning approvals, health care regulatory approvals to establish a hospital or health care facility, including certificates of need, then Buyer shall be permitted to file all necessary applications to secure such approvals so long as Buyer makes application within sixty (60) days following the commencement of the Feasibility Period. Seller agrees to cooperate with Buyer in connection with filing of any applications, including executing applications as the owner of the Property, all charge to Buyer.

a. **Books, Records, Leases, Agreements.** Seller shall make available for inspection by Buyer and its agents within ten (10) days after Mutual Acceptance all documents in Seller's possession or control relating to the ownership, operation, renovation or development of the Property, excluding appraisals or other statements of value, and including: statements for real estate taxes, assessments, and utilities for the last three years and year to date; property management agreements and any other agreements with professionals or consultants; leases or other agreements relating to occupancy of all or a portion of the Property and a suite-by-suite schedule of tenants, rents, prepaid rents, deposits and fees; plans, specifications, permits, applications, drawings, surveys, and studies; maintenance records, accounting records and audit reports for the last three years and year to date; and "Vendor Contracts" which shall include maintenance or service

INITIALS: Buyer CH Date 1/21/2019 Seller KRC Date 1-17-19
Buyer _____ Date _____ Seller C.G. Date 1/17/19

Seller KRC Date: 01/17/19

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CBA Form PS-1A
Purchase & Sale Agreement
Rev. 1/2011
Page 4 of 17

contracts, and installments purchase contracts or leases of personal property or fixtures used in connection with the Property. Buyer shall determine within the Feasibility Period: (i) whether Seller will agree to terminate any objectionable Vendor Contracts; and (ii) whether Seller will agree to pay any damages or penalties resulting from the termination of objectionable Vendor Contracts. Buyer's waiver of the Feasibility Contingency shall be deemed Buyer's acceptance of all Vendor Contracts which Seller has not agreed in writing to terminate. Buyer shall be solely responsible for obtaining any required consents to such assumption and the payment of any assumption fees. Seller shall cooperate with Buyer's efforts to receive any such consents but shall not be required to incur any out-of-pocket expenses or liability in doing so. Seller shall transfer the Vendor Contracts as provided in Section 17.

b. **Access.** Seller shall permit Buyer and its agents, at Buyer's sole expense and risk to enter the Property at reasonable times subject to the rights of and after legal notice to tenants, to conduct inspections concerning the Property and improvements, including without limitation, the structural condition of improvements, hazardous materials, pest infestation, soils conditions, sensitive areas, wetlands, or other matters affecting the feasibility of the Property for Buyer's intended use. Buyer shall schedule any entry onto the Property with Seller in advance and shall comply with Seller's reasonable requirements including those relating to security, confidentiality, and disruption of Seller's tenants. Buyer shall not perform any invasive testing including environmental inspections beyond a phase I assessment or contact the tenants or property management personnel without obtaining the Seller's prior written consent, which shall not be unreasonably withheld. Buyer shall restore the Property and improvements to the same condition they were in prior to inspection. Buyer shall be solely responsible for all costs of its inspections and feasibility analysis and has no authority to bind the Property for purposes of statutory liens. Buyer agrees to indemnify and defend Seller from all liens, costs, claims, and expenses, including attorneys' and experts' fees, arising from or relating to entry onto or inspection of the Property by Buyer and its agents. This agreement to indemnify and defend Seller shall survive closing. Buyer may continue to enter the Property in accordance with the foregoing terms and conditions after removal or satisfaction of the feasibility contingency only for the purpose of leasing or to satisfy conditions of financing.

c. Buyer waives the right to receive a seller disclosure statement ("Form 17-Commercial") if required by RCW 64.06. However, if Seller would otherwise be required to provide Buyer with a Form 17-Commercial, and if the answer to any of the

INITIALS:	Buyer ^{ds} <u>CH</u>	Date <u>1/21/2019</u>	Seller <u>KRE</u>	Date <u>1-17-19</u>
	Buyer _____	Date _____	Seller <u>C.G.</u>	Date <u>1/17/19</u>
			Seller <u>CTC</u>	Date: <u>01/17/19</u>

questions in the section of the Form 17-Commercial entitled "Environmental" would be "yes," then Buyer does not waive the receipt of the "Environmental" section of the Form 17-Commercial which shall be provided by Seller.

6. TITLE INSURANCE AND SURVEY.

a. **Title Report and Survey.** Seller authorizes Buyer, at Seller's expense, to apply for and deliver to Buyer a standard extended (standard, if not completed) coverage owner's policy of title insurance. If an extended coverage owner's policy is specified, Buyer shall pay the increased costs associated with that policy including the excess premium over that charged for a standard coverage policy, and the cost of any survey required by the title insurer. The title report shall be issued by Chicago Title Insurance Company. Buyer shall pay any title cancellation fee, in the event such a fee is assessed. Seller authorizes Buyer to obtain an ALTA survey for the Property at the Buyer's sole cost and expense

b. **Permitted Exceptions.** Buyer shall notify Seller of any objectionable matters in the title report or the survey or any supplemental report within the earlier of: (1) 45 days after Mutual Acceptance of this Agreement; or (2) the expiration of the Feasibility Period. This Agreement shall terminate and Buyer shall receive a refund of the earnest money, less any costs advanced or committed for Buyer, unless within fifteen (15) days of Buyer's notice of such objections (1) Seller agrees, in writing, to remove all objectionable provisions or (2) Buyer notifies Seller that Buyer waives any objections which Seller does not agree to remove. If any new title matters are disclosed in a supplemental title report or revisions to the survey, then the preceding termination, objection and waiver provisions shall apply to the new title matters and the revised survey except that Buyer's notice of objections must be delivered within ten (10) days of delivery of the supplemental report or receipt of revised survey and Seller's response or Buyer's waiver must be delivered within two (2) days of Buyer's notice of objections. The Closing date shall be extended to the extent necessary to permit time for these notices. Buyer shall not be required to object to any mortgage or deed of trust liens, or the statutory lien for real property taxes, and the same shall not be deemed to be Permitted Exceptions; provided, however, that the lien securing any financing which Buyer has agreed to assume shall be a Permitted Exception. Except for the foregoing, those provisions not objected to or for which Buyer waived its objections shall be referred to collectively as the "Permitted Exceptions." Seller shall cooperate with Buyer and the title company to clear objectionable title and survey matters but shall not be required to incur any out-of-pocket expenses ^{or} liability other than payment of monetary encumbrances not assumed by

INITIALS: Buyer CH Date 1/21/2019 Seller KRC Date 1-17-19
Buyer _____ Date _____ Seller C.D. Date 1/17/19
Seller [Signature] Date 1/17/19

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CBA Form PS-1A
Purchase & Sale Agreement
Rev. 1/2011
Page 6 of 17

Buyer and proration of real property taxes, and Seller shall provide an owner's affidavit containing the information and reasonable covenants requested by the title company. The title policy shall contain no exceptions other than the general exclusions and exceptions common and commercially reasonable to such form of policy and the Permitted Exceptions.

7. **CLOSING OF SALE.** The sale shall be closed within ten (10) days following the expiration of the Feasibility Period ("Closing") by Chicago Title Insurance Company – National Commercial Services – Seattle, WA office – C/o Paula Adams ("Closing Agent"). Buyer and Seller shall deposit with Closing Agent by 12:00 p.m. on the scheduled Closing date all instruments and monies required to complete the purchase in accordance with this Agreement. "Closing" shall be deemed to have occurred when the deed is recorded and the sale proceeds are available to Seller. Time is of the essence in the performance of this Agreement. Sale proceeds shall be considered available to Seller, even though they cannot be disbursed to Seller until the next business day after Closing. Notwithstanding the foregoing, if Seller informed Buyer during the Feasibility Period that Seller's underlying financing requires that it be defeased and may not be paid off, then Closing shall be conducted in accordance with the three-day closing process described in CBA Form PS_D. This Agreement is intended to constitute escrow instructions to Closing Agent. Buyer and Seller will provide any supplemental instructions requested by Closing Agent provided the same are consistent with this Agreement.

8. **CLOSING COSTS AND PRORATIONS.** Seller shall deliver an updated rent roll to Closing Agent not later than two (2) days before the scheduled Closing date in the form required by this Section 8 and any other information reasonably requested by Closing Agent to allow Closing Agent to prepare a settlement statement for Closing. Seller certifies that the information contained in the rent roll is correct as of the date submitted. Seller shall pay the premium for the owner's standard coverage title policy. Buyer shall pay the excess premium attributable to any extended coverage or endorsements requested by Buyer, and the cost of any survey required in connection with the same. Seller and Buyer shall each pay one-half of the escrow fees and any recording fees. Seller shall pay any real estate excise taxes and transfer taxes. Real and personal property taxes and assessments payable in the year of closing; collected rents on any existing tenancies; interest; utilities; and other operating expenses shall be pro-rated as of Closing. If tenants pay any of the foregoing expenses directly, then Closing Agent shall only pro rate those expenses paid by Seller. Buyer shall pay to Seller at Closing an additional sum equal to any utility deposits or mortgage reserves for assumed financing for which Buyer receives

INITIALS: Buyer CA Date 1/21/2019 Seller KRC Date 1-17-19
Buyer _____ Date _____ Seller C.G. Date 1/17/19
Seller WTZ Date: 01/17/19

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CBA Form PS-1A
Purchase & Sale Agreement
Rev. 1/2011
Page 7 of 17

the benefit after Closing. Buyer shall pay all costs of financing including the premium for the lender's title policy. If the Property was taxed under a deferred classification prior to Closing, then Seller shall pay all taxes, interest, penalties, deferred taxes or similar items which result from removal of the Property from the deferred classification. At Closing, all refundable deposits on tenancies shall be credited to Buyer or delivered to Buyer for deposit in a trust account if required by state or local law. Buyer shall pay any sales or use tax applicable to the transfer of personal property included in the sale.

a. **Unpaid Utility Charges.** Buyer and Seller WAIVE DO NOT WAIVE (do not waive if neither box checked) the right to have the Closing Agent disburse closing funds necessary to satisfy unpaid utility charges affecting the Property pursuant to RCW 60.80. If "do not waive" is checked, then attach CBA Form UA ("Utility Charges" Addendum) to this Agreement.

9. **POST-CLOSING ADJUSTMENTS, COLLECTIONS, AND PAYMENTS.** After Closing, Buyer and Seller shall reconcile the actual amount of revenues or liabilities upon receipt or payment thereof to the extent those items were prorated or credited at Closing based upon estimates. Any bills or invoices received by Buyer after Closing which relate to services rendered or goods delivered to the Seller or the Property prior to Closing shall be paid by Seller upon presentation of such bill or invoice. At Buyer's option, Buyer may pay such bill or invoice and be reimbursed the amount paid plus interest at the rate of 12% per annum beginning fifteen (15) days from the date of Buyer's written demand to Seller for reimbursement until such reimbursement is made. Notwithstanding the foregoing, if tenants pay certain expenses based on estimates subject to a post-closing reconciliation to the actual amount of those expenses, then Buyer shall be entitled to any surplus and shall be liable for any credit resulting from the reconciliation. Rents collected from each tenant after Closing shall be applied first to rentals due most recently from such tenant for the period after closing, and the balance shall be applied for the benefit of Seller for delinquent rentals owed for a period prior to closing. The amounts applied for the benefit of Seller shall be turned over by Buyer to Seller promptly after receipt. Seller shall be entitled to pursue any lawful methods of collection of delinquent rents but shall have no right to evict tenants after Closing.

10. **OPERATIONS PRIOR TO CLOSING.** Prior to Closing, Seller shall continue to operate the Property in the ordinary course of its business and maintain the Property in the same or better condition than as existing on the date of Mutual Acceptance but shall not be required to repair material damage from casualty except as otherwise provided in this Agreement. After the date of Mutual Acceptance, Seller shall not enter into or

INITIALS: Buyer [Signature] Date 1/21/2019 Seller KRC Date 1-17-19
Buyer _____ Date _____ Seller CJ Date 1/17/19
Seller VJR Date 01/17/19

modify existing rental agreements or leases (except that Seller may enter into, modify, extend, renew or terminate residential rental agreements or residential leases in the ordinary course of its business), service contracts, or other agreements affecting the Property which have terms extending beyond Closing without first obtaining Buyer's consent, which shall not be unreasonably withheld.

11. **POSSESSION.** Buyer shall be entitled to possession on closing _____ (on closing, if not completed). Buyer shall accept possession subject to all tenancies disclosed to Buyer during the Feasibility Period.

12. **SELLER'S REPRESENTATIONS.** Except as disclosed to or known by Buyer prior to the satisfaction or waiver of the feasibility contingency stated in Section 5 above, including in the books, records and documents made available to Buyer, or in the title report or any supplemental report or documents referenced therein, Seller represents to Buyer that, to the best of Seller's actual knowledge, each of the following is true as of the date hereof: (a) Seller is authorized to enter into the Agreement, to sell the Property, and to perform its obligations under the Agreement; (b) The books, records, leases, agreements and other items delivered to Buyer pursuant to this Agreement comprise all material documents in Seller's possession or control regarding the operation and condition of the Property; (c) Seller has not received any written notices that the Property or the business conducted thereon violate any applicable laws, regulations, codes and ordinances; (d) Seller has all certificates of occupancy, permits, and other governmental consents necessary to own and operate the Property for its current use; (e) There is no pending or threatened litigation which would adversely affect the Property or Buyer's ownership thereof after Closing; (f) There is no pending or threatened condemnation or similar proceedings affecting the Property, and the Property is not within the boundaries of any planned or authorized local improvement district; (g) Seller has paid (except to the extent prorated at Closing) all local, state and federal taxes (other than real and personal property taxes and assessments described in Section 8 above) attributable to the period prior to closing which, if not paid, could constitute a lien on Property (including any personal property), or for which Buyer may be held liable after Closing; (h) Seller is not aware of any concealed material defects in the Property except as disclosed to Buyer in writing during the Feasibility Period; (i) There are no Hazardous Substances (as defined below) currently located in, on, or under the Property in a manner or quantity that presently violates any Environmental Law (as defined below); there are no underground storage tanks located on the Property; and there is no pending or threatened investigation or remedial action by any governmental agency regarding the release of Hazardous

INITIALS: Buyer CA Date 1/21/2019 Seller KRC Date 1-17-19
Buyer _____ Date _____ Seller C.O. Date 1/17/19
seller KRC Date 01/17/19

Substances or the violation of Environmental Law at the Property. As used herein, the term "Hazardous Substances" shall mean any substance or material now or hereafter defined or regulated as a hazardous substance, hazardous waste, toxic substance, pollutant, or contaminant under any federal, state, or local law, regulation, or ordinance governing any substance that could cause actual or suspected harm to human health or the environment ("Environmental Law"). The term "Hazardous Substances" specifically includes, but is not limited to, petroleum, petroleum by-products, and asbestos. If prior to Closing Seller or Buyer discovers any information which would cause any of the representations above to be false if the same were deemed made as of the date of such discovery, then the party discovering the same shall promptly notify the other party in writing. If the newly-discovered information will result in costs or liability to Buyer in excess of the lesser of \$100,000 or five percent (5%) of the purchase price stated in this Agreement, or will materially adversely affect Buyer's intended use of the Property, then Buyer shall have the right to terminate the Agreement and receive a refund of its earnest money. Buyer shall give notice of termination within five (5) days of discovering or receiving written notice of the new information. Nothing in this paragraph shall prevent Buyer from pursuing its remedies against Seller if Seller had actual knowledge of the newly-discovered information such that a representation provided for above was false.

- 13. **AS-IS.** Except for those representations and warranties specifically included in this Agreement: (i) Seller makes no representations or warranties regarding the Property; (ii) Seller hereby disclaims, and Buyer hereby waives, any and all representations or warranties of any kind, express or implied, concerning the Property or any portion thereof, as to its condition, value, compliance with laws, status of permits or approvals, existence or absence of hazardous material on site, occupancy rate or any other matter of similar or dissimilar nature relating in any way to the Property, including the warranties of fitness for a particular purpose, tenantability, habitability and use; (iii) Buyer otherwise takes the Property "AS IS;" and (iv) Buyer represents and warrants to Seller that Buyer has sufficient experience and expertise such that it is reasonable for Buyer to rely on its own pre-closing inspections and investigations.

14. **PERSONAL PROPERTY.**

a. This sale includes all right, title and interest of Seller to the following tangible personal property: None That portion of the personal property located on and used in connection with the Property, which Seller will itemize in an Exhibit to be attached to this Agreement within ten (10) days of Mutual Acceptance (None, if not completed). The value assigned to the personal property shall be \$ _____ (if not completed, the County-

INITIALS: Buyer CA Date 1/21/2019 Seller KRC Date 1-17-19
Buyer _____ Date _____ Seller C.J. Date 1/17/19
Seller KRC Date 01/17/19

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CBA Form PS-1A
Purchase & Sale Agreement
Rev. 1/2011
Page 10 of 17

assessed value if available, and if not available, the fair market value determined by an appraiser selected by the Buyer at Seller's sole cost and expense). Seller warrants title to, but not the condition of, the personal property and shall convey it by bill of sale at Closing.

b. In addition to the leases and Vendor Contracts assumed by Buyer pursuant to Section 5(a) above, this sale includes all right, title and interest of Seller to the following intangible property now or hereafter existing with respect to the Property including without limitation: all rights-of-way, rights of ingress or egress or other interests in, on, or to, any land, highway, street, road, or avenue, open or proposed, in, on, or across, in front of, abutting or adjoining the Property; all rights to utilities serving the Property; all drawings, plans, specifications and other architectural or engineering work product; all governmental permits, certificates, licenses, authorizations and approvals; all rights, claims, causes of action, and warranties under contracts with contractors, engineers, architects, consultants or other parties associated with the Property; all utility, security and other deposits and reserve accounts made as security for the fulfillment of any of Seller's obligations; any name of or telephone numbers for the Property and related trademarks, service marks or trade dress; and guaranties, warranties or other assurances of performance received.

15. **CONDEMNATION AND CASUALTY.** Seller bears all risk of loss until Closing, and thereafter Buyer shall bear the risk of loss. Buyer may terminate this Agreement and obtain a refund of the earnest money if improvements on the Property are destroyed or materially damaged by casualty before Closing, or if condemnation proceedings are commenced against all or a portion of the Property before Closing. Damage will be considered material if the cost of repair exceeds the lesser of \$100,000 or five percent (5%) of the purchase price stated in this Agreement. Alternatively, Buyer may elect to proceed with closing, in which case, at Closing, Seller shall assign to Buyer all claims and right to proceeds under any property insurance policy and shall credit to Buyer at Closing the amount of any deductible provided for in the policy.

16. **FIRPTA - TAX WITHHOLDING AT CLOSING.** Closing Agent is instructed to prepare a certification (CBA or NWMLS Form 22E, or equivalent) that Seller is not a "foreign person" within the meaning of the Foreign Investment in Real Property Tax Act, and Seller shall sign it on or before Closing. If Seller is a foreign person, and this transaction is not otherwise exempt from FIRPTA, Closing Agent is instructed to withhold and pay the required amount to the Internal Revenue Service.

INITIALS:	Buyer ^{DS} CH	Date 1/21/2019	Seller KRC	Date 1-17-19
	Buyer _____	Date _____	Seller C.J.	Date 1/17/19
			Seller KRC	Date 01/17/19

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CBA Form PS-1A
Purchase & Sale Agreement
Rev. 1/2011
Page 11 of 17

- 17. **CONVEYANCE.** Title shall be conveyed by a Statutory Warranty Deed subject only to the Permitted Exceptions. If this Agreement is for conveyance of Seller's vendee's interest in a Real Estate Contract, the Statutory Warranty Deed shall include a contract vendee's assignment sufficient to convey after acquired title. At Closing, Seller and Buyer shall execute and deliver to Closing Agent CBA Form No. PS-AS Assignment and Assumption Agreement transferring all leases and Vendor Contracts assumed by Buyer pursuant to Section 5(a) and all intangible property transferred pursuant to Section 14(b).

- 18. **NOTICES AND COMPUTATION OF TIME.** Unless otherwise specified, any notice required or permitted in, or related to, this Agreement (including revocations of offers and counteroffers) must be in writing. Notices to Seller must be signed by at least one Buyer and must be delivered to Seller and Listing Broker with a courtesy copy to any other party identified as a recipient of notices in Section 28. A notice to Seller shall be deemed delivered only when received by Seller, Listing Broker, or the licensed office of Listing Broker. Notices to Buyer must be signed by at least one Seller and must be delivered to Buyer, with a copy to Selling Broker and with a courtesy copy to any other party identified as a recipient of notices in Section 28. A notice to Buyer shall be deemed delivered only when received by Buyer, Selling Broker, or the licensed office of Selling Broker. Selling Broker and Listing Broker have no responsibility to advise of receipt of a notice beyond either phoning the represented party or causing a copy of the notice to be delivered to the party's address provided in this Agreement. Buyer and Seller shall keep Selling Broker and Listing Broker advised of their whereabouts in order to receive prompt notification of receipt of a notice. If any party is not represented by a licensee, then notices must be delivered to and shall be effective when received by that party at the address, fax number, or email indicated in Section 28.

Unless otherwise specified in this Agreement, any period of time in this Agreement shall mean Pacific Time and shall begin the day after the event starting the period and shall expire at 5:00 p.m. of the last calendar day of the specified period of time, unless the last day is a Saturday, Sunday or legal holiday as defined in RCW 1.16.050, in which case the specified period of time shall expire on the next day that is not a Saturday, Sunday or legal holiday. Any specified period of five (5) days or less shall not include Saturdays, Sundays or legal holidays. Notwithstanding the foregoing, references to specific dates or times or number of hours shall mean those dates, times or number of hours; provided, however, that if the Closing Date falls on a Saturday, Sunday, or legal holiday as defined in RCW 1.16.050, or a date when the county recording office is closed, then the Closing Date shall be the next regular business day.

INITIALS: Buyer ^{DS} CH _____ Date 1/21/2019 Seller KRC _____ Date 1-17-19
 Buyer _____ Date _____ Seller C.G. _____ Date 1/17/19
 Seller KRC Date: 01/17/19

19. AGENCY DISCLOSURE. At the signing of this Agreement,

Tyler Springer and Jordan Springer of SRE Commercial ("Seller's Broker") represented Seller.

Buyer is not represented by a real estate salesperson or broker.

20. ASSIGNMENT. Buyer may may not (may not, if not completed) assign this Agreement, or Buyer's rights hereunder, without Seller's prior written consent; provided, however, Buyer may only assign its rights under this Agreement to an entity that Buyer or an affiliate of Buyer has engaged to develop the Property for Buyer's intended purpose.

21. DEFAULT AND ATTORNEY'S FEE.

a. Buyer's default. In the event Buyer fails, without legal excuse, to complete the purchase of the Property, then (*check one*):

Seller may terminate this Agreement and keep the earnest money as liquidated damages as the sole and exclusive remedy available to Seller for such failure; or

Seller may, at its option, (a) terminate this Agreement and keep as liquidated damages the earnest money as the sole and exclusive remedy available to Seller for such failure, (b) bring suit against Buyer for Seller's actual damages, (c) bring suit to specifically enforce this Agreement and recover any incidental damages, or (d) pursue any other rights or remedies available at law or equity.

b. Seller's default. In the event Seller fails, without legal excuse, to complete the sale of the Property, then (*check one*):

As Buyer's sole remedy, Buyer may either (a) terminate this Agreement and recover all earnest money or fees paid by Buyer whether or not the same are identified as refundable or applicable to the purchase price; or (b) bring suit to specifically enforce this Agreement and recover incidental damages, provided, however, Buyer must file suit within sixty (60) days from the scheduled date of closing or from the date Seller has informed Buyer in writing that Seller will not proceed with closing, whichever is earlier; or

INITIALS: Buyer DS
CH Date 1/21/2019 Seller KRC Date 1-17-19
Buyer _____ Date _____ Seller C.G. Date 1/17/19
Seller ETC Date: 01/17/19

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CBA Form PS-1A
Purchase & Sale Agreement
Rev. 1/2011
Page 13 of 17

Buyer may, at its option, (a) bring suit against Seller for Buyer's actual damages, (b) bring suit to specifically enforce this Agreement and recover any incidental damages, or (c) pursue any other rights or remedies available at law or equity.

Neither Buyer nor Seller may recover consequential damages such as lost profits. If Buyer or Seller institutes suit against the other concerning this Agreement, the prevailing party is entitled to reasonable attorneys' fees and expenses. In the event of trial, the amount of the attorney's fee shall be fixed by the court. The venue of any suit shall be the county in which the Property is located, and this Agreement shall be governed by the laws of the state where the Property is located.

22. MISCELLANEOUS PROVISIONS.

a. **Complete Agreement.** This Agreement and any addenda and exhibits thereto state the entire understanding of Buyer and Seller regarding the sale of the Property. There are no verbal or other written agreements which modify or affect the Agreement.

b. **Counterpart Signatures.** This Agreement may be signed in counterpart, each signed counterpart shall be deemed an original, and all counterparts together shall constitute one and the same agreement.

c. **Electronic Delivery.** Electronic delivery of documents (e.g., transmission by facsimile or email) including signed offers or counteroffers and notices shall be legally sufficient to bind the party the same as delivery of an original. At the request of either party, or the Closing Agent, the parties will replace electronically delivered offers or counteroffers with original documents.

d. **Section 1031 Like-Kind Exchange.** If either Buyer or Seller intends for this transaction to be a part of a Section 1031 like-kind exchange, then the other party agrees to cooperate in the completion of the like-kind exchange so long as the cooperating party incurs no additional liability in doing so, and so long as any expenses (including attorneys fees and costs) incurred by the cooperating party that are related only to the exchange are paid or reimbursed to the cooperating party at or prior to Closing. Notwithstanding Section 20 above, any party completing a Section 1031 like-kind exchange may assign this Agreement to its qualified intermediary or any entity set up for the purposes of completing a reverse exchange.

INITIALS:	Buyer	CH ^{DS}	Date	1/21/2019	Seller	KRC	Date	1-17-19
	Buyer	_____	Date	_____	Seller	C.G.	Date	1/17/19
					Seller	KTZ	Date	01/17/19

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CBA Form PS-1A
Purchase & Sale Agreement
Rev. 1/2011
Page 14 of 17

23. **ACCEPTANCE; COUNTEROFFERS.** Seller has until 5:00 p.m. Pacific Time on January 18, 2019 to accept this offer, unless sooner withdrawn. If this offer is not timely accepted, it shall lapse and the earnest money shall be refunded to Buyer. If either party makes a future counteroffer, the other party shall have until 5:00 p.m. on third business day following receipt to accept the counteroffer, unless sooner withdrawn. If the counteroffer is not timely accepted or countered, this Agreement shall lapse and the earnest money shall be refunded to the Buyer. No acceptance, offer or counteroffer from the Buyer is effective until a signed copy is received by the Seller. No acceptance, offer or counteroffer from the Seller is effective until a signed copy is received by the Buyer. "Mutual Acceptance" shall occur when the last counteroffer is signed by the offeree, and the fully-signed counteroffer has been received by the offeror, his or her broker, or the licensed office of the broker. If any party is not represented by a broker, then notices must be delivered to and shall be effective when received by that party.

24. **INFORMATION TRANSFER.** In the event this Agreement is terminated, Buyer agrees to deliver to Seller within ten (10) days of Seller's written request copies of all materials received from Seller and any non-privileged plans, studies, reports, inspections, appraisals, surveys, drawings, permits, applications or other development work product relating to the Property in Buyer's possession or control as of the date this Agreement is terminated.

25. **CONFIDENTIALITY.** Until and unless closing has been consummated, Buyer and Seller shall follow reasonable measures to prevent unnecessary disclosure of information obtained in connection with the negotiation and performance of this Agreement. Neither party shall use or knowingly permit the use of any such information in any manner detrimental to the other party. Notwithstanding the foregoing, Buyer may disclose this Agreement and information obtained in connection with the negotiation and performance of this Agreement to the extent reasonably necessary to (a) secure approvals necessary to operate a hospital or health care facility on the Property, (b) collaborate with other hospitals and health care providers who may elect to participate in the ownership and/or operation of the hospital or health care facility that may be constructed on the Property, (c) secure investors or purchasers for Buyer's intended use of the Property, (d) secure advice from Buyer's legal counsel, affiliates, and financial advisors, and (e) to the extent required by a court order or by law.

26. **SELLER'S ACCEPTANCE AND BROKERAGE AGREEMENT.** Seller agrees to sell the Property on the terms and conditions herein, and further agrees to pay a commission ^{DS} in a total amount computed in accordance with the listing or commission

INITIALS: Buyer CH Date 1/21/2019 Seller KRC Date 1-17-19
Buyer _____ Date _____ Seller C.J. Date 1/17/19
Seller KCR Date 01/17/19

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CBA Form PS-1A
Purchase & Sale Agreement
Rev. 1/2011
Page 15 of 17

agreement. If there is no written listing or commission agreement, Seller agrees to pay a commission of 5% of the sales price to the Seller's Broker. The Property described in attached Exhibit A is commercial real estate.

27. **LISTING BROKER AND SELLING BROKER DISCLOSURE.** EXCEPT AS OTHERWISE DISCLOSED IN WRITING TO BUYER OR SELLER, BROKERS HAVE NOT MADE ANY REPRESENTATIONS OR WARRANTIES OR CONDUCTED ANY INDEPENDENT INVESTIGATION CONCERNING THE LEGAL EFFECT OF THIS AGREEMENT, BUYER'S OR SELLER'S FINANCIAL STRENGTH, BOOKS, RECORDS, REPORTS, STUDIES, OR OPERATING STATEMENTS; THE CONDITION OF THE PROPERTY OR ITS IMPROVEMENTS; THE FITNESS OF THE PROPERTY FOR BUYER'S INTENDED USE; OR OTHER MATTERS RELATING TO THE PROPERTY, INCLUDING WITHOUT LIMITATION, THE PROPERTY'S ZONING, BOUNDARIES, AREA, COMPLIANCE WITH APPLICABLE LAWS (INCLUDING LAWS REGARDING ACCESSIBILITY FOR DISABLED PERSONS), OR HAZARDOUS OR TOXIC MATERIALS INCLUDING MOLD OR OTHER ALLERGENS. SELLER AND BUYER ARE EACH ADVISED TO ENGAGE QUALIFIED EXPERTS TO ASSIST WITH THESE DUE DILIGENCE AND FEASIBILITY MATTERS, AND ARE FURTHER ADVISED TO SEEK INDEPENDENT LEGAL AND TAX ADVICE RELATED TO THIS AGREEMENT.

28. **DISPUTE RESOLUTION.** In the event a dispute shall arise between the parties to this Agreement, and the parties are unable to resolve the dispute between them, the dispute shall be submitted to mediation, and the parties will engage in the mediation process in good faith once a written request for mediation has been received by either party from the other. If mediation does not resolve the dispute, the matter shall be submitted to binding arbitration before an agreed neutral arbitrator. Said submission shall occur within 30 days of a written demand for arbitration from one party to the other. The arbitration shall be governed by the Commercial Arbitration Rules of the American Arbitration Association. Washington law shall govern all disputes and venue shall lie in Snohomish County, Washington.

29. **IDENTIFICATION OF THE PARTIES.** The following is the contact information for the parties involved in this Agreement:

Buyer:

Seller:

INITIALS:	Buyer		Date	1/21/2019	Seller	KRC	Date	1-17-19
	Buyer		Date		Seller	C.G.	Date	1/17/19
					Seller	1012	Date	01/17/19

IN WITNESS WHEREOF, the parties have signed this Agreement intending to be bound.

Buyer KINDRED HEALTHCARE
OPERATING, LLC

Buyer DocuSigned by:
Cleve Haralson
9775F874A7684DA
Signature and title
Date signed 1/21/2019

Seller TREE OWL PROPERTIES LLC

Seller Kenneth R. Campbell
Kenneth R. Campbell, President
Date signed Jan. 17, 2019

Seller Carol June
Carol June, Vice-President

Date signed Jan. 17, 2019

Seller Katherine F. Campbell
Katherine F. Campbell, Secretary

Date signed Jan. 17, 2019

INITIALS: Buyer CH Date 1/21/2019 Seller KRC Date 1-17-19
Buyer _____ Date _____ Seller C.J. Date 1/17/19
Seller KRC Date 01/17/19

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CBA Form PS-1A
Purchase & Sale Agreement
Rev. 1/2011
Page 18 of 17

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INITIALS: Buyer CA^{DS} Date 1/21/2019 Seller KRC Date 1-17-19
Buyer _____ Date _____ Seller C.A. Date 1/17/19
Seller KAL Date 1/17/19

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CBA Form PS-1A
Purchase & Sale Agreement
Rev. 1/2011
Page 19 of 17

EXHIBIT A *

Those parcels of land more particularly described below, which are commonly known as Snohomish County, Washington tax parcels: 00568700101100; 00568700101200; and 00568700101300.*

LEGAL DESCRIPTION

PARCEL A BEFORE ADJUSTMENT:

LOT 11, BLOCK 1, SERENE ACRES, ACCORDING TO THE PLAT THEREOF RECORDED IN VOLUME 12 OF PLATS, PAGE 32 IN SNOHOMISH COUNTY, WASHINGTON.

PARCEL B BEFORE ADJUSTMENT:

LOT 12, BLOCK 1, SERENE ACRES, ACCORDING TO THE PLAT THEREOF RECORDED IN VOLUME 12 OF PLATS, PAGE 32 IN SNOHOMISH COUNTY, WASHINGTON.

PARCEL C BEFORE ADJUSTMENT:

LOT 13, BLOCK 1, SERENE ACRES, ACCORDING TO THE PLAT THEREOF RECORDED IN VOLUME 12 OF PLATS, PAGE 32 IN SNOHOMISH COUNTY, WASHINGTON.

PARCEL A AFTER ADJUSTMENT:

LOT 11, 12 AND 13, BLOCK 1, SERENE ACRES, ACCORDING TO THE PLAT THEREOF RECORDED IN VOLUME 12 OF PLATS, PAGE 32 RECORDS OF SNOHOMISH COUNTY, WASHINGTON AND ALSO AS SHOWN ON A RECORD OF SURVEY RECORDED UNDER AUDITOR'S FILE NUMBER 201402115001, RECORDS OF SNOHOMISH COUNTY, WASHINGTON.

*The legal description shall be mutually agreed upon after Seller and Buyer have reviewed the title commitment and survey of the Property.

INITIALS:	Buyer ^{DS} <u>CH</u>	Date <u>1/21/2019</u>	Seller <u>KRC</u>	Date <u>1-17-19</u>
	Buyer _____	Date _____	Seller <u>C.G.</u>	Date <u>1/17/19</u>
			Seller <u>KRC</u>	Date <u>01/17/19</u>

Exhibit 9

Potential Developer Letter of Intent and Term Sheet



April 12th, 2019

Mr. Cleve Haralson
Vice President Real Estate & Capital Development
Kindred Healthcare
113 Seaboard Lane, STE B201
Franklin, TN 37067

RE: 12911 Beverly Park Road, Lynnwood, WA

Dear Cleve,

Pacific Medical Buildings ("PMB") proposes to develop, finance, construct and own a 40-bed Inpatient Rehabilitation Hospital ("IRF") in partnership with Kindred Healthcare, LLC ("Kindred") and Northwest Washington Rehabilitation Hospital ("NWRH"), Kindred and NWRH referred to collectively as the "Joint Venture".

The site (consisting of approximately 4.40 acres) located at 12911 Beverly Park Road in Lynwood, WA, (the "Property") is currently under contract by Kindred with intent to assign the Property to PMB under terms of a purchase and sale agreement ("PSA") should a final Development Agreement be mutually executed between the parties (the "Development Agreement"). Upon assignment, PMB will be required to close on the Property and construct the 40-bed Facility, based on Kindred's design.

After construction, PMB will lease the IRF to the Joint Venture. The lease is referred to as the "Lease". The Lease would contain the terms set forth below in the section titled "Proposed Transaction Terms".

Proposed Transaction Terms:

The Joint Venture will enter into the Development Agreement with PMB for the development, financing and construction of the proposed IRF that will be a two-story building of approximately 53,000 SF. The Development Agreement will provide that the Lease will have a 15-year primary term with three 10-year renewal options. The Joint Venture will occupy the facility pursuant to a "Net-Net-Net" lease with all operating costs to be passed-through to the Joint Venture. The form of the Lease will be attached to the final Development Agreement as an exhibit.

To assure that the Joint Venture's programmatic requirements are met, the Development Agreement will further provide that the final building design will be completed by an architectural firm selected by the Joint Venture. At completion of the final construction budget as agreed to by the parties, the developer will guarantee completion of the project within the agreed upon budget and construction schedule. The Development Agreement and Lease will provide the Joint Venture with appropriate remedies in the event the developer fails to timely and properly complete the facility. These remedies will include an outside date for project completion, payment of liquidated damages (on a per diem basis) if the developer fails to achieve substantial completion in a timely manner, a purchase option and self-help rights. It is expected that PMB will use a competitive bid process to select the general contractor and subcontractors, with the Joint Venture having the right to approve the same (unless the Joint Venture has already selected a general contractor). If a general contractor has not already been

selected, a list of approved general contractors will be provided to PMB prior to bidding. In addition, at the Joint Venture's option, PMB shall reimburse the Joint Venture for the costs it incurs in connection with the proposed transaction; provided PMB may include these costs in the development budget.

The Lease will grant the Joint Venture an option to acquire the IRF (including the land, building and other improvements) at any time after the seventh (7th) year of the Lease (including during any renewal or extension). In addition, the Lease will grant the Joint Venture a right of first refusal and a right of first offer to acquire the Property. No brokerage commissions shall be payable upon the acquisition of the IRF by the Joint Venture, and the Joint Venture shall receive a credit against the price for the estimated transaction costs savings resulting from its purchase of the Property (to be more particularly defined in the Lease).

It is the goal of PMB and the Joint Venture to break ground as soon as possible following the receipt of all regulatory approvals. This may require a pre-approved agreement to proceed at-risk on the design documents to maintain the project schedule. The IRF is intended to commence operations 12-13 months after ground breaking, with the building being substantially complete and receiving final certificate of occupancy within approximately 11-12 months. The Joint Venture will have a 30-day period following receipt of the certificate of occupancy to install its furnishings, equipment and other personal property prior to the commencement of the term of the Lease (and rent). Groundbreaking is expected to commence Winter 2019/2020.

Qualifications:

- PMB is the largest and most experienced third-party developer of healthcare facilities in the West. In 2018, PMB was recognized by Revista as the country's leading healthcare developer as measured by project completions. PMB's development philosophy is to have our Partners and most experienced team members provide hands on management and oversight of all project management. Mark Toothacre and Doug Clerget will lead and co-manage development activities for the Joint Venture. Mark is PMB's President and has been with PMB for 30-years. Doug is PMB's VP of Development and is officed in Seattle providing PMB and the Joint Venture an excellent boots-on-the-ground local presence. John Hussey and Peter Jeong will provide design management and construction management services. John is a PMB partner and has been with PMB for 22 years. Peter is an experienced construction project executive who successfully managed Kindred's Indianapolis project.
- This project team is a known quantity to Kindred that has successfully delivered Kindred's Indianapolis project and has also positioned the Kindred Palomar project for successful delivery with construction starting shortly.
- PMB is intimately familiar with the Kindred project documents and has built a strong working relationship with Kindred's legal team, and ESa, the pre-selected architect.

Recent PMB Projects:

PMB Project	Dollar Value	Project Description	Projected Completion
Community Rehabilitation Hospital South Greenwood, IN	\$19M	44-bed, 54,000 SF conversion of an LTACH to an inpatient rehabilitation facility	7/2018
Palomar Rehabilitation Institute Escondido, CA	\$40M	52-bed 56,000 SF inpatient rehabilitation facility	Expected Q1 2020
Lakeway Regional Hospital Lakeway, TX	\$211M	106-bed inpatient hospital	7/2012
Gencare Lifestyle at Point Ruston Tacoma, WA	\$64M	144,000 SF (159-unit) independent living, assisted living and memory care	7/2019
Gencare Lifestyle at Steel Lake Federal Way, WA	\$23M	103-unit independent living, assisted living and memory care	2/2020
1100 Van Ness San Francisco, CA	\$167M	9-story, 250,000sf w/ 383 space subterranean parking garage	12/2018
Clinicas de Salud del Pueblo FQHC El Centro, CA	\$26M	44,000 SF build-to-suit FQHC clinic	11/2018
Superior MOB Superior, CO	\$19M	60,00 SF MOB with structured parking	3/2019
Goodyear Medical MOB Goodyear, AZ	\$18M	Repositioning of a theater to 50,000 SF MOB	6/2019
Mercy Gilbert MOB Gilbert, AZ	\$23M	80,000 SF MOB	4/2019

PMB's recent development experience in the Seattle area and the Northwest includes:

- 159-unit, \$62M senior living facility in Tacoma, WA which will open in August (2019)
- PMB recently purchased an existing, 103-unit, \$23M senior living project in Federal Way, WA. The development plan provides for a complete renovation of the property to reposition in the marketplace.
- PMB was just awarded a 150,000 square, \$110M MOB with Virginia Mason which will be part of a mixed-use high-rise development adjacent to the Virginia Mason campus in downtown Seattle, WA.
- PMB has a property management office in Vancouver, WA and currently manages 370,000 SF in the Pacific Northwest market.

PMB's acute and post-acute experience includes projects in Lakeway TX, Indianapolis, and Escondido. These projects are profiled in the table above.

References:

Andrew Haslam, Chief Asset Officer
Providence St. Joseph Health
1801 Lind Avenue SW
Renton, WA
503.349.1025

Rich Mencil, Administrative Director, Support Services
Virginia Mason
1100 9th Avenue
Seattle, WA
206.341.0949

Sandy Smith, SVP of Real Estate
Hoag Memorial Hospital Presbyterian
One Hoag Drive
P.O. Box 6100
Newport Beach, CA
949.764.1900

Bob Mitsch, VP Facility Planning & Development
Sutter Health
2880 Gateway Oaks Dr., Suite 220
Sacramento, CA
916.566.4800

Lou Orlando
Dignity Health (Common Spirit Health)



3400 Data Drive
Rancho Cordova, CA
916.631.3317

Debra Cafaro, CEO
Ventas, Inc.
353 North Clark Street, Suite 3300
Chicago, IL 60603
312.660.3318

Mark Burkemper, Managing Director
Harrison Street
444 West Lake Street
Suite 2100
Chicago, IL 60606
312.376.0134

Schedule:

PMB understands that the certificate of need (“CON”) process which recently commenced will take approximately six months. Using a fast-track design, permitting and procurement approach would allow the project to break ground in Winter 2019/2020. We anticipate a 12 to 13-month construction period with building occupancy by Spring 2021. PMB is expert in hands-on management of entitlement and permitting processes achieving the earliest possible construction starts and building occupancies.

John Hussey and Peter Jeong provide skilled analysis and support of our general contractor in the sub-contractor procurement, buyout and scheduling processes.

Financials:

- Development Fee: 3.0% of total project costs (Excluding Development Fee and Interest)
- Base Rental Rate: 7.60% of total project costs
- Annual Rent Escalation: 2.25% per annum
- PMB will assume the Kindred’s position in the PSA to acquire the land and will adhere to the due diligence and closing timelines set forth therein
- PMB will reimburse Kindred for costs to date and will fund future costs for project design work
- Design work will proceed concurrently with the CON approval process
- PMB will require reimbursement language in the Development Agreement consistent with our previous Kindred projects
- PMB will require lease guarantees from Kindred and NWRH with burn off language consistent with previous PMB/Kindred deals



- PMB has the flexibility, relationships and market knowledge to match the best financing to each of its projects. Equity capital would be provided by either institutional capital or private capital. If institutional equity is used, Harrison Street Real Estate Capital, which has financed five projects for PMB including both Kindred IRF projects would be the most logical choice. Ventas REIT is PMB's programmatic development partner and would be available for this project, if acceptable to Kindred. PMB also has a deep reservoir of individual high net worth investors that it uses to fund projects.
- Construction financing will likely be provided by one of PMB's customary construction lenders which include: City National Bank, Wells Fargo, Capital One, JP Morgan Chase and Farmers and Merchants Bank.
- PMB will not charge a leasing fee, property management fee, or other overhead fees payable to PMB as developer.

This project is an exciting opportunity and an equally great responsibility. With PMB, Kindred and the Joint Venture will receive a team with extensive healthcare knowledge across the continuum of care, real estate development experience focused solely on healthcare, the ability to execute projects on time and on budget and a known, long-term partner. We look forward to continued discussions regarding this exciting development. Thank you again for this opportunity.

Sincerely,

Mark Toothacre
President

Doug Clerget
VP Development

Exhibit 10

Equipment List

Northwest Washington Rehabilitation Hospital, LLC
 Equipment List

Equipment Type	Qty
1" Bariatric Tapered Extention Total	2
1" Tapered Extention, Base: Porcelain Total	2
10" Parrallel Bar - Mortized, H & W, Base: Porcelain Total	1
16" Bariatric Parrellel Bar, Motorized Total	1
5-Leg, pneumatic, exam/laboratory stool, chrome, black composite base, 22"-29"H Total	16
Acro/Storage bin, 6 5/8 W x 11 5/8 D x 4 H - sandstone Total	24
Acro/Storage bin, 4 1/8 W x 11 5/8 D x 4 H - sandstone Total	72
Acro/Storage bin, 8 3/8 W x 6 5/8 D x 4 H - sandstone Total	48
Acrylic Wheelchair Tray Total	2
ADL Kitchen Cooking Equipment (dinnerware, utensils, cooking equipment, pots and pans) Total	1
AED Defibrillator/monitor, wall mounted Total	2
Airex Balance Pad, Blue Total	2
Akro-Tilt Truck Med Duty 100 Total	1
Apothecary Weight Set Total	1
Bailey Foot Placement Ladder Total	1
BALANCE SYSTEM SD 115V (12.1" LCD) Total	1
Ball Rack, Horizontal PVC, Mobile, Holds 6 Balls, 62"W x 22"D x 62"H Total	1
Bariatric Skin Protection Wheelchair Cushion - 22" x 18" x 4" Total	1
BARIMATT Foam Matt Total	2
Baseline 360 degree clear plastic goniometer, 12 inches Total	1
Baseline 360 degree clear plastic goniometer, 6 inches Total	1
Baseline 360 degree clear plastic goniometer, 8 inches Total	1
Baseline 3-piece hand evaluation set (dynamometer, Pinch gauge, goniometer) Total	2
Baseline 9 hole pegboard Total	2
Basic Shoulder Exerciser with Dual Pulley & Door Bracket Total	1
Basket for sphygmomanometer, wall mounted Total	1
Bed, electric w/o mattress, scale, sidecom rails, Bariatric Total	2
Bed, electric w/o mattress, scale, sidecom rails, S3 Custom Total	30
Bed, low w/o mattress, scale/bed exit alarm Total	10
Bladder scanner w/cart Total	2
BodySport Anti-Burst Gymball with Pump - 45cm Total	1
BodySport Gymball w/Pump 85cm Total	1
Boston DAE 3 Long Form Record Booklets (25) Total	1
BOSU Pro Balance Dome Total	1
Bowl Mop, , White, Plastic Total	6
Brute 32 Gallon Garbage Can Total	2
Bucket disinfecting Total	3
Buffing Pads Red Total	1
Cabinet for AED Defibrillator, wall mounted w/ alarm-surface mount, rolled edges Total	2
Cando Folding Mat w/Handles - 5' x 7' - 2" Polyurethane Total	2
Cando gel hand exercise ball, large, 6-piece set (tan through black) Total	1
Cando gel hand exercise ball, small, 6-piece set (tan through black) Total	1
Cando Wate bar, 1 pound Total	1
Cando Wate bar, 2 pound Total	1
Cando Wate bar, 3 pound Total	1
Cando Wate bar, 4 pound Total	1
Cando Wate bar, 5 pound Total	1
Cando Wate bar, 7 pound Total	1
Cando Wate bar, 8 pound Total	1
Cane and Crutch Rack Total	2
Canyon Balance Bo-Bath 2 Section Treatment Table Total	2
Car Total	1
Card Rack Total	1
Carpet Extractor Total	1
Carpeted Entrance Mat,Charcoal,4 x 6 ft. Total	4
Cart, CLEAN linen, HD transport cart W/ SOLID BOTTOM SHELF w/cover - 24 D x 60 W x 69 H - with cover Total	8
Cart, emergency/crash, portable Total	2
Cart, environmental service Total	3
Cart, Linen w/casters and cover Total	1
Cart, Soiled Linen Total	3
Cart, Supply Total	1
Cart, Supply w/casters and cover Total	5
Cash Register - Station AIO-Pro Cashier Total	1
Chattanooga DRYING RACK Total	1
Chemical dispenser, four product (PROVIDED BY VENDOR UNDER OPERATIONAL CONTRACT) Total	3
Cnvrtbl Hnd Trck,1000 lb.,61 x 23" Total	1
ColPac Chilling Unit -Model C-5 - Includes (6) Standard and (6) Half Size Total	1
Comfort Cushion - Dual Layer Foam Wheelchair Cushion - 16" x 18" x 3" Total	1
COMFORT GEL Surface w/ MedSurg Frame Total	10
Commode, BARIATRIC, 650lbs capacity Total	4
Communication Board Total	1

Northwest Washington Rehabilitation Hospital, LLC
 Equipment List

Equipment Type	Qty
Container, SHARPS, collector InRoom, 5.4qt, RED Total	70
Container, SHARPS, needle disposal wall enclosure, 5.4QT cap., Brown tinted, wall mounted Total	56
Crutches, Tall - 5'10" - 6'6" Total	1
Cuff, large ADULT; complete inflation system w/ cuff, bladder, bulb, valve latex free Total	1
Cuff, large CHILD; complete inflation system w/ cuff, bladder, bulb, valve latex free Total	1
Cut End Dust Mop,White,36 In. L,5 In. W Total	1
Defibrillator/monitor w/ ECG Total	2
Deluxe Electric H-Low Mat Table, Steel Frame, Electric Adjustable Backrest 4x7 Total	1
Digi-Flex Complete Set with Plastic Display (5) (One of each Level) Total	1
Dishwasher, ADA, residential, undercounter Total	1
Dishwasher, ADA, residential, undercounter, STAINLESS Total	2
Disinfectant Mop Bucket,28 Qt.,Ylw/Gry Total	3
Disinfecting hand foam dispenser, wall mounted Total	112
Dispenser specular for 524 series, wall mounted Total	1
Dispenser, DisinfectingHand Foam w/ Splash Guard, Wall Mounted Total	2
Dispenser, glove, triple, wire, wall mounted Total	80
Dispenser, Soap/Foam, Wall Mounted Total	1
Dolly Base for RCP 2620 GRA Total	2
Dolly Base for RCP 2655 GRA Total	6
Dolly Base for RCP 2655 RED Total	6
Dolly Base for RCP 8632-92 GRA Total	2
double curved shoulder arc Total	1
Drain cleaning machine, powerfeed w/ 5/16" x 35'-0" cable Total	1
Drive Medical Bariatric Folding Commode Total	4
Drive Medical Cruiser III Wheelchair, 16", Desk Arm, Elevating Legrest Total	2
Drive Medical Cruiser III Wheelchair, 18", Desk Arm, Elevating Legrest Total	8
Drive Medical Cruiser III Wheelchair, 20", Desk Arm, Elevating Legrest Total	9
Drive Medical Molded General Use Wheelchair Cushion 16" x 16" x 2" Total	1
Drive Medical Molded General Use Wheelchair Cushion 16" x 18" Total	1
Drive Medical Sentra Bariatric Extra Heavy Duty Wheelchair, 20", Detachable Arm, Elevating Legrest Total	3
Drive Medical Sentra Bariatric Extra Heavy Duty Wheelchair, 20", Detachable Arm, Swing Away Foot Rests Total	3
Drive Medical Sentra EC Bariatric Wheelchair Extra Wide 30" Width Total	1
Drive Medical Three Piece Transfer Tub Bench Total	2
Dryer, laundry, electric, WHITE Total	2
Dust Mop Frame, 36In. Total	4
Dust Mop Frame,24 In.L Total	6
Dust Mop Handle,60In.,Wood,Natural Total	4
Dust Mop, Yellow,24 In. L,5 In. W Mfg Total	4
Easi-Care CAM Lock Gait Belt - 72" Total	1
Economy Stacking Cone Set Total	1
Economy Wash Bottle, 4 oz pkg/6 Total	8
EKG machine with cart/trolley and mobilelink Total	1
EksoBionic Suit Total	1
Electric Metronome Total	1
Ergometer Total	1
Exertools 55cm Gymball Total	1
Exertools 65cm Gymball Total	1
Exertools 75cm Gymball Total	1
Exertools Activity Column - Wall Mounted / Fixed Bracket (Pair) / Universal Receiving Tube Total	1
Exertools Activity Column Adjustable Shoulder Wheel Total	1
Exertools Activity Column Extended Bar Total	1
Exertools Activity Column Long Shelf Total	1
Exertools Activity Column Short Shelf Attachment Total	1
Exertools Activity Column Stabilizer Bar Attachment Total	1
Exertools Plyoback Relfex Rebounder Package Total	1
Exertools Professional Dual Multi Slant Total	1
Exertools Professional Wobble/Rocker Board Package Total	1
Fablifegait Belt with Quick release Buckle - 60 Total	1
Fablifegait Belt with Quick release Buckle - 72 Total	1
Finger Prehension Task Total	1
Flammable Safety Cabinet,12 Gal.,Yellow Total	1
Floor Machine Total	1
Floor Scrubber Total	1
Floor style powder board table Total	1
Flowmeter, O2 Total	50
Forma Thermaplastic Spint Pan - 28.5 x 21 x 7 Total	1
Freight Total	1
Freight Charges for Smallwares, Food Service Items Total	1
Functional Cuff Weight Set (1ea 1,2,3,4,5,7,5,10lb) Total	2
Functional Push-Up Blocks Total	1
GaitKeeper 2000T Treadmill Total	1

Northwest Washington Rehabilitation Hospital, LLC
Equipment List

Equipment Type	Qty
Glass Funnel 16 oz Total	1
Glass Funnel 4oz Total	1
Glass Graduate Cylinder 5mL Total	1
Glass Graduated Cylinder 100mL Total	1
Glass Mortar and Pestle Kit - Includes One (1) Each: Flint Glass Pestle 2 oz (PT #3080), Flint Glass Mortar 4 oz (PT #3072), Flint Glass Pestle 4 oz (PT #3082), Flint Glass Mortar 8 oz (PT #3074), Flint Glass Pestle 8 oz (PT #3084), Flint Glass Pestle 1	1
Glass Ointment Slab 3/4in Thick Total	1
Glassine Paper 5-15/16 x 4-3/8 Total	1
Glucometer, meter kit w/ RF Total	4
Graded Pinch Exerciser Total	1
Graham Field Bariatric Skin Protection Wheelchair Cushion - 30" x 19" x 4" Total	1
Hand truck, convertible, 1000lb capacity Total	1
Hangers for Disposable Isolation Station Total	10
Hausmann 3 in 1 Training Staircase Total	1
Hausmann Crank Adjustable Hi-Lo Butcher Block Table - 66" x 48" Total	2
Hausmann Cubex Therapy System on Wheels Total	1
Hausmann Duplex Pulley Weights, (2) Handles at Chest Level & (2) Handles Total	1
Hausmann Electric Work Table Total	3
Hausmann Mini Staircase Total	1
Hausmann Mobile Cabinet for Splinting and Supplies Total	1
Hausmann Mobile Cuff Weight & Dumbbell Rac Total	2
HCL Class II Pharmacy Scale 320g Ext Cal Total	1
Heavy Duty Foot Stool 500 lb. Weight Capacity Total	1
HIGH VOLUME AIR PUMP Total	1
Hitachi Vibrator Total	1
Holding Mitt, Large, 11" Total	1
Holding Mitt, Medium, 10 1/4" Total	1
Holding Mitt, Small, 9" Total	1
Homecraf Bowl Holder w/Bowl Total	1
Homecraft Over-Stove Mirror Total	1
Hood, horizontal, laminar flow, workstation, 37"W x 34"D x 49.5"H Total	1
Hooks for PegBoards, 11pcs Total	1
horizontal ring tree Total	1
Hoses, Cords, Vents Total	2
Hospital isolation Bag Total	3
Hospital Isolation Bag,40 In. L,PK100 Total	1
Hospital Isolation Bag,Red,Star,PK100 Total	1
Hydrocollator™ Mobile Heating Unit Model M-2 - Includes (3) Standard Hotpacs, (3) oversize and (3) cervical Total	1
Ice machine, air cooled, countertop Total	4
Ideal Offset Cart Total	1
Infusion pump,single unit, pole mounted Total	10
Intelect™ Legend XT - 2-Channel Combination with Cart Total	2
Jay J2 Wheelchair Cushion 17" x 17" Total	1
Ladder, 10'-0" fiberglass Total	1
LARK-2: Language Activity Resource Kit – Second Edition Total	1
Lid for RCP 2655 GRA Total	6
Lid for RCP 2655 RED Total	6
Lid for RCP 8632-92 GRA Total	2
LiteGait I-360E with FlexAble Yoke Total	1
LiteGait Integrated FreeDome Total	1
Lumex 5 Fixed Walker Wheels, Pair Total	5
Lumex Aluminum Adjustable Offset Bariatric Cane Total	1
Lumex Aluminum Adjustable Offset Cane, Bronze, Ortho-Ease Standard Total	1
Lumex Aluminum Adjustable Offset Cane, Standard Grip, Standard Length Total	2
Lumex Aluminum Adjustable Offset Cane, Standard Grip, Standard Length (31"-39") Total	1
Lumex Bariatric Bath Seat w/Backrest Total	32
Lumex Dual Release X-Wide Folding Walker Total	5
Lumex Everyday Dual Release Walker with 5" Wheels – Adult Total	1
Lumex Everyday Dual Release Walker with 5" Wheels – Junior – 4/Case Total	1
Lumex Everyday Dual Release Walker, Adult - 2/Case Total	1
Lumex Everyday Dual Release Walker, Adult - 4/Case Total	2
Lumex Everyday Dual Release Walker, Junior - 4/Case Total	2
Lumex Fast Alert Basic Patient Alarm with Chair Pad Total	10
Lumex Padded Transfer Bench Total	2
Lumex Pressure Sensative Chair Pad Total	10
Lumex Silver Collection Low Profile Quad Cane, Aluminum, Ortho-Ease Grip, Small Base (8" x 6") Total	4
Lumex Silver Collection Low Profile Quad Cane, Aluminum, Ortho-Ease® Grip, Large Base (12" x 8") Total	3
Lumex Standard Wood Cane, Derby Style, Walnut Finish Imperial (Bariatric) Total	1

Northwest Washington Rehabilitation Hospital, LLC
 Equipment List

Equipment Type	Qty
Lumex Sure-Safe Bathtub Rail Total	1
Mabis Deluxe Gait Belt Total	1
Markers and magnetic caddy for communication board Total	50
Med Warming Cab C Bar Total	1
Medication Dispensing Unit Total	6
Medication Dispensing Units Total	6
Microfiber Damp Pad,18 In.,Blue Mfg Total	4
Mobility Workstation for Carescape V100 Total	10
Monitor, pulse oximeter Total	2
Mop Handle,58In.,Aluminum,Yellow Total	2
Mop,Loop End,Medium Total	3
Narcotic Lock box for refrigerator Total	1
Naugahyde Bolster 6" x 24" - Taupe Total	5
Naugahyde Wedge, 10" x 24" x 28", Taupe Total	4
Naugahyde Wedge, 8" x 24" x 28" - Taupe Total	2
Nested Steps, Set of 4 Total	2
neurological (Buck) hammer Total	1
NK Electric Hi-Lo Stand-In Table Total	1
NK Steel Frame Electric Hi-Lo Mat Table - 4' x 7' Total	3
NK Steel Frame Electric Hi-Lo Mat Table - 6' x 8' Total	2
NuStep T4R Recumbent Cross Trainer Total	1
OptiFlex® K-1 Knee CPM with Standard Pendant Total	4
Otoscope/Ophthalmoscope, desk set, diagnostic Total	1
Oven, microwave, countertop Total	5
Oven, microwave, countertop, STAINLESS Total	2
Oven/range, electric w/ glass oven door, front controls, self cleaning, freestanding. STAINLESS Total	2
Overhead patient lift, 21' straight "J" track Total	1
Overhead patient lift, 28' straight "J" track Total	1
Oxygen tank cylinder stand, 12capacity - 22"W x 15"D x 19.5" H - weight - 19 lbs Total	1
Pad Holder,18 In Total	2
Paper Towel Dispenser, Hardwood, (1) Roll. Mfg Brand Name: Gerogia Pacific; Mfg Part No: 59488 Total	88
Paper Towel Dispenser, Paper Towel Sheets Mfg Brand Name: Gerogia Pacific; Mfg Part No: 56620 Total	79
Patient Floor Lift, Electric with Battery Recharge, Medium & Large Sling Total	1
Patient Lift Total	9
Pillows, fluid resistant and reusable, 24oz, 20" x 26" Total	100
Pivot Disc, 18" Total	1
Plastic Card Holder Total	1
Platform Walker Attachment (Pair) Total	1
Pole for infusion pump Total	10
Power Hand Grip Total	1
Precision Spot Heat Gun Total	1
Premier Wheelchair Arm Tray Total	5
PROFORM Surface w/ Medsurge Frame Total	33
Psychological Assesment, Boston Name Testing - PAR Total	1
Push Button Aluminum Crutches - Youth - 37" to 45" Total	1
PVC Pipe Tree Total	2
Ramp & curb training set Total	1
Reference Book - Pharmacy drug information handbook Total	1
Reference Book - Pharmacy handbook on Injectable drugs Total	1
Refrigerator, 4.3 cu ft, undercounter, WHITE Total	3
Refrigerator, Medication, undercounter Total	5
Refrigerator, Pharmacy, Glass Door Total	1
Refrigerator/freezer, 20.5 cu.ft., upright STAINLESS Total	2
Refrigerator/freezer, 20.5 cu.ft., upright WHITE Total	5
Regulator, Suction Total	50
Reminiscence Bingo Total	1
Residential Coffee Maker Total	1
Roberts Book Holder Total	1
ROHO Quadro Select High Profile Wheelchair Cushion - 19" x 19" Total	1
Rolling Cabinet,26 1/2 W,3 Drawer,Red Total	1
Rubber Spatula Kit - Includes Three (3) Each: Rubber Spatula 6 Inch Blade (PT #3095), Rubber Spatula 8 Inch Blade (PT #3095), Rubber Spatula 4 Inch Blade (PT #3091) Total	1
Rubbermaid Cart for patient admission and discharge Total	2
Saebo Ball Activity - 4 Tier Total	1
Saebo Hemi-Glide Plus Total	1
Saebo MAS Total	1
Safe Total	1
Safe, Pharmacy upright Total	1
Safety Cabinet,Can Total	1
Safety Cards in the Home Total	1
Safety In and Around the Home Total	1

Northwest Washington Rehabilitation Hospital, LLC
 Equipment List

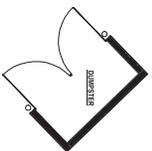
Equipment Type	Qty
Scale, Wheelchair Total	2
Scrubbing Pads Green 13' Total	1
Scrubbing Pads Green 20" Total	1
Seabo Peg Activity, 5 Ball Total	1
Seabo Target Height Adjustable Total	1
semi-circular peg board Total	1
Shelf Bin "10-3/4" x 8-1/4" x 7" Total	144
Shelf Bin "10-7/8" x 4-1/8" x 4" Total	180
Shelf Bin "14-3/4" x 8-1/4" x 7" Total	144
Shelf Bin 11 5/8 x 6 5/8 Total	24
Shelf Bin 11 5/8 x 8 3/8 Total	48
Shelf Bin 4 1/8 x 11 5/8 Total	72
Shelf Bin"18" x 16-1/2" x 11" Total	30
Shelving, wire, starter, 36 x 18 x 74, 5 shelves, including foot glides Total	55
Shoehorn, Metal, 24 inch Total	10
shoulder incline board Total	1
Shower Chair Total	49
Skillbuilders Arm/Hand Elevator w/Water Resistant Coating Total	1
Small exercise skate Total	1
Soap dispenser, HAIR/BODY, wall mounted, BLACK Total	51
Soap dispenser, wall mounted Total	160
Solution Tank Total	1
Speech therapy, A Selection of Stimulus Materials-Volume #1 Total	3
Speech therapy, Advanced Stimulus Materials-Volume #2 Total	3
Speech Therapy, ALFA Assessment of Language Related Total	3
Speech Therapy, Apraxia of Speech Stimulus Library Total	3
Speech therapy, Boston Name Testing Total	3
Speech Therapy, Boston Naming Test Record Booklet (set of 25) Total	3
Speech Therapy, Cambridge Test of Prospective Memory Total	6
Speech therapy, CLQT-Cognitive Linguistic Quick Test Total	3
Speech therapy, CLQT-Test Booklet Total	3
Speech Therapy, Critical Thinking, 2 Book bundle W/TMS; '13 Catalog Total	3
Speech Therapy, Lark-2 Language Activity Resource Kit Total	3
Speech Therapy, Mini-Inventory of Right Brain Injury Total	3
Speech Therapy, photo cue cards Total	3
Speech therapy, RBANS-Record Form A Total	3
Speech therapy, RBANS-Record Form B Total	3
Speech therapy, RBANS-Repeatable Battery for Assessment of Neuropsychological Status Total	3
Speech therapy, Reading Comprehension Materials-Volume #5 Total	3
Speech Therapy, Ross Information Processing Assessment Total	3
Speech Therapy, Source for Apraxia therapy Total	3
Speech therapy, The Memory Box Total	2
Speech therapy, WALC-1 Total	3
Speech therapy, WALC-10-Memory Total	3
Speech therapy, WALC-11 Total	3
Speech therapy, WALC-2 Total	3
Speech therapy, WALC-3 Total	3
Speech therapy, WALC-4-Everyday Reading Total	3
Speech therapy, WALC-5-Neuro Rehab Total	3
Speech therapy, WALC-6-Functional Language Total	3
Speech therapy, WALC-9-Verbal and Visual Reasoning Total	3
Speech Therapy, Western Aphasia Battery Revised Total	3
Speech Therapy, Workbook for Cognitive Skills Total	3
Speech therapy, Workbook of Cognitive Skill 2nd Edition Total	3
Sphygmomanometer, aneroid with cuff and basket, wall mounted Total	1
Sports Art Rehab Recumbent Cycle Total	1
Sports Art Upper Body Ergometer Total	1
SportsArt Medical Treadmill T635M Total	1
Stainless Steel Spatula Kit - Includes Three (3) Each: Stainless Steel Spatula 6 Inch Blade (PT #3028), Stainless Steel Spatula 8 Inch Blade (PT #3029), Stainless Steel Spatula 10 Inch Blade (PT #3429), Stainless Steel Spatula 4 Inch Blade (PT #3042)	1
Stand for hood, 3'-0" stainless steel Total	1
Standard Unloading Harness Total	1
STDAS-2: Screening Test for Developmental Apraxia of Speech - Second Edition Total	1
Step Stool,Black,15 In. H Total	1
Step-on hamper, chrome, white poly-coated steel lid, 18-5/8"W x 19-1/2"D x 37-3/4"H" Total	59
STEP-STOOL, BALANCE SD Total	1
Sterile Protection Organizers Total	10
Stopwatch, Digital Readout Total	1
Stryker Renaissance Stretcher Total	1

Northwest Washington Rehabilitation Hospital, LLC
 Equipment List

Equipment Type	Qty
Suction machine w/ AC, portable Total	2
Supplies for Pharmacy Allowance Total	1
Table, Butcher Block - adjustable Total	1
Table, patient overbed w/ split-top Total	40
Tech-Med Digital Timer Total	1
TechMed Digital Timer with Clock Total	1
Technobody Iso-Free Total	1
Television, flat screen, 32" RCA,HDTV,Hosp Grd, Slvr, ATSC Total	51
Television, flat screen, 42"w/ speaker w/ 1/4 to 1/4 jumper Total	6
Television, flat screen, 55" Total	1
Therafin Figure 8 Board System Total	1
Therafin Jux-A-Cisor Arm Exerciser Total	2
Toilet Paper Dispr, Coreless, 7 1/8 in. H Mfg Brand Name: Gerogia Pacific; Mfg Part No: 56797 Total	68
Toilet seat, BARI-elevated locking Total	1
Toilet seat, raised Total	1
Tool Set,Master,396pc Total	1
Training Aid for Vascular access/external and peripheral catheters Total	1
Transfer Board, Theraslide, 24 W/2 Perpendicular Hand Holes, 650lb Capacity Total	1
Trash Bags - 10 gal Total	1
Trash Bags - 30 gal Total	1
Trash bags - 33 gal Total	1
Trash Bags,60 gal.,16 micron,PK200 Total	1
Traveler HD Wheelchair 20X18 Detachable Desk Arm, Elevating Legrest Total	3
Traveler HD Wheelchair 20X18 Detachable Full Arm, Swingaway Footrest Total	3
Traveler SE Wheelchair, 16x16 Detachable Desk Arm, Swingaway Footrest Total	2
Traveler SE Wheelchair, 18x16 Detachable Desk Arm, Elevating Legrest Total	8
Traveler SE Wheelchair, 18x16 Detachable Full Arm, Elevating Legrest Total	9
Trigger Sprayer Total	30
Two Way Radio,VHF,2 Watts,2 Channels Total	2
Upright Vacuum,14 In,120 cfm,10A,120V Total	2
Utility Cart,750 lb. Load Cap. Total	1
Vacuum, portable Total	1
Vending machine, snack/food/beverage, freestanding Total	2
Visual Perception Test Kit Total	1
Vital Signs Monitor - Carescape V100 w/pole and cuffs Total	10
VitalStim Portable Kit, Adult Total	2
WALC 1 Aphasia Rehab - Workbook of Activities for Language and Cognition Total	1
WALC 10 Memory - Workbook of Activities for Language and Cognition Total	1
WALC 11 Language for Home Activities - Workbook of Activities for Language and Total	1
WALC 2 Cognitive Rehab - Workbook of Activities for Language and Cognition Total	1
WALC 3 Everyday Problem Solving - Workbook of Activities for Language and Total	1
WALC 5 Neurological Rehab Workbook of Activities for Language and Cognition Total	1
WALC 6 Functional Language - Workbook of Activities for Language and Cognition Total	1
WALC 9 Verbal and Visual Reasoning - Workbook of Activities for Language and Total	1
Walk & Cut Cordless Can Opener Total	1
Walkabout Contour Deluxe Four Wheel Rollator - Burgandy Total	5
Walkcane Hemi Walker Total	6
Wall mount, articulating, 22-40", blk, ph Total	51
Wall mount, flat tilt, 55" Total	1
Wall Mount, Tilt Mt Total	6
Warehousing Fee Allowance Total	1
Washer, laundry, WHITE Total	2
Waste Receptacle Total	4
Waste Receptacle, 12 Gallon w/Lid Lifter, Beige Total	93
Waste Receptacle, 20 Gallon Brute, Gray - no lid needed Total	2
Waste Receptacle, 23 Gallon w/Lid Lifter, Beige Total	3
Waste Receptacle, 40 Quart, Beige Total	127
Waste Receptacle, 55 Gallon, Gray Total	6
Waste Receptacle, 55 Gallon, Red Total	6
Water filter system Total	4
WaxWel Paraffin Bath with 6lb. unscented paraffin PLUS liners, mitt and bottie Total	1
Wet Mop,White,Medium Total	3
Wheelchair Auto Style Seat Belt Total	1
Wheelchairs Total	5
Work table, maintenance, WOOD top Total	1
Work/Therapy Table Total	1
Yes-U-Can Fine Motor Kit Total	1

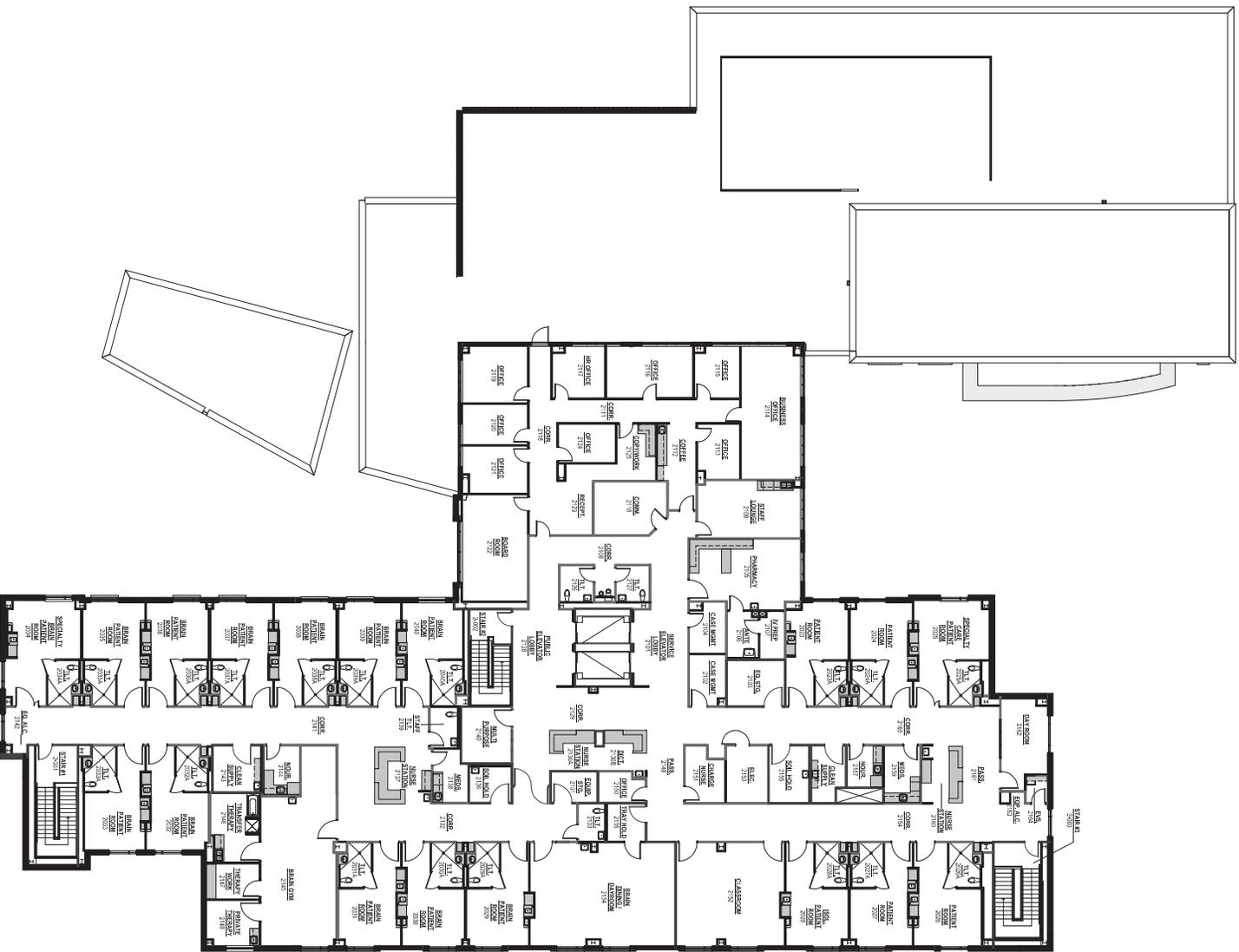
Exhibit 11

Single Line Drawings



1ST FLOOR PLAN

SCALE: 1/16" = 1'-0"



2ND FLOOR PLAN

SCALE: 1/16" = 1'-0"

Exhibit 12

Documentation of Zoning



About the Property Report

Report Generated On: 1/7/2019 10:23:24 AM

This report contains information regarding the subject property. This information may be useful for land developers, agents, and planners when analyzing potential land use changes.

The information in this report was compiled from the Snohomish County geographic information system (GIS). Data sources include several Snohomish County departments as well as federal, state, and local agencies.

Please note that all information contained in this report is subject to the disclaimer as noted at the bottom of each page and the end of the report.

Larger-sized map images are included at the end of this report.

Significant information that can affect permitting are displayed in **red text**.



General Location Info

Site Address:	UNKNOWN UNKNOWN
City:	UNKNOWN
Zip:	No Data
Tax Parcel Number:	00568700101100
QTR-Sec-Twp-Rng:	SE 27 T28N R 4E : SW 27 T28N R 4E
Latitude / Longitude:	Lat=47.880449
<small>(NAD83)</small>	Long=-122.281584
WA State Plane North Zone:	X=1,285,060.34
<small>(NAD83, US Feet)</small>	Y=324,502.15
County Road Atlas Page:	123

Administrative Info

Land Use Jurisdiction:	City of Mukilteo : Snohomish County
Tribal Lands Status:	Non-tribal land
Tribal Lands Name:	Non-tribal land



Planning Info

Future Land Use (FLU):	CITY : UCOM : UI
FLU Description:	Incorporated City : Urban Commercial : Urban Industrial
Zoning:	BP : CITY : PCB
Zoning Description:	Business Park : City : Planned Community Business
QTR-Sec-Twp-Rng:	SE 27 T28N R 4E : SW 27 T28N R 4E
Tax Parcel Number:	00568700101100
Urban Growth Area (UGA):	Southwest County UGA
Municipal UGA:	MUKILTEO : MUKILTEO MUGA
Transportation ILA:	Not in an Transportation Interlocal Agreement Area
TDR Sending Area:	Not in a TDR Sending area
TDR Receiving Area:	Not in a TDR Receiving area
Snow Load Factor:	0.049
Snow Load:	To obtain snow load value, turn on 'Snowload' layer in interactive map and click on the area of interest
No-Shooting Area:	Inside a No-shooting Area (SCC 10.12)
Lot Status:	Unconfirmed
SCC 30.23.040 (22) Applies:	Minimum Lot Size does not apply {per SCC 30.23.040(22)}
Transportation Services Area:	D
Mineral Resource Type:	Not in an Mineral Resource area
Mineral Resource Name:	Not in a mineral resource overlay area
Shoreline Management Area:	Not in a Shoreline Management Area



Planning and Development Services Property Report

Assessor Info

Tax Parcel: 00568700101100

Owner Name: TREE OWL PROPERTIES LLC

Taxpayer of Record: TREE OWL PROPERTIES LLC
(maintained by Treasurer)

Site Address: UNKNOWN UNKNOWN
City: UNKNOWN
Zip: No Data

Use Code: 910 Undeveloped (Vacant) Land

Gross Size (acres): 1.92

Land Value: \$978,000
Improvement Value: \$0

Total Value: \$978,000

Tax Year: 2018
Assessment Date: 01/01/2017

Property Account Summary: https://www.snoco.org/proptax/search.aspx?parcel_number=00568700101100

Permit Information: <http://www.snoco.org/app/pds/permitstatus/PDS-ParcelList.aspx?PN=00568700101100>



Planning and Development Services Property Report

District Info

Council District:	County Council District 2 : County Council District 3
Fire District:	Fire District 01
Fire Authority:	South Sno. Co. Fire & Rescue Rfa
School District:	Mukilteo School District 6
Sewer District:	Not in a sewer district
Water District:	Alderwood Water And Wastewater District
Water Provider (CWSP):	Alderwood Water and Wastewater District
Park District:	Not in a park district
Park Service Area:	Nakeeta Beach
Drainage District:	Not in a drainage district
Diking District:	Not in a diking district
Flood Control District:	Not in a flood control district

Notification Info

Agriculture Notification Area:	Not within an agriculture notification area
Lahar Volcanic Notice (200 ft):	Not in a lahar hazard area
Commercial Forrest Notice (500 ft):	Not within 500 ft of a commercial forest
Mineral Resource Notice (2000 ft):	Not within 2,000 ft of a Mineral Resource Overlay area
Paine Field Airport:	Inside height restriction area (FAA Form 7460-1)
Airpark:	No airparks within 2500 ft
Airport Compatibility Area:	Paine Field Airport
Airport Influence Area:	Paine Field Airport



Critical and Physical Info

Watershed Name:	Cedar-Sammamish watershed
Aquifer Sensitivity:	Low Aquifer Sensitivity
Elevation: (NAVD88, US Feet)	Approximately 574.8 to 593.1 ft
Sub-basin Name:	Puget Sound Drainage sub-basin
Hydric Soils:	No hydric soils Hydric soils present
Basin Name:	Puget Sound
Flood Hazard Area:	Parcel is outside the flood hazard area
Sole Source Aquifer:	Not in a sole source aquifer
Water Resource Inventory Area:	WRIA 8
Flood Plain 100yr:	n/a
Critical Aquifer Recharge Area:	Not in a critical aquifer recharge area
Geology (erodible surface):	Vashon till
Soil Type:	ALDERWOOD-URBAN LAND COMPLEX, 2 TO 8 PERCENT SLOPES
National Wetlands Inventory:	No NWI wetlands present
Wetlands (Snoco):	No PDS wetlands present
Wetlands Last Edited:	No PDS wetlands present
Steep Slopes (> 33%):	Steep slopes not detected
Landslide Hazard Area:	Not within a known landslide and outside the modeled LHA area More Information: SCC 30.62B.340
Mine Hazard:	No mines within 200 feet
Pipelines:	No petroleum pipelines within 1,000 feet
Levees:	No levees within 1,000 feet
Levees Source:	No levee on the property
Data Compiled On:	01/06/2019



Planning and Development Services Property Report

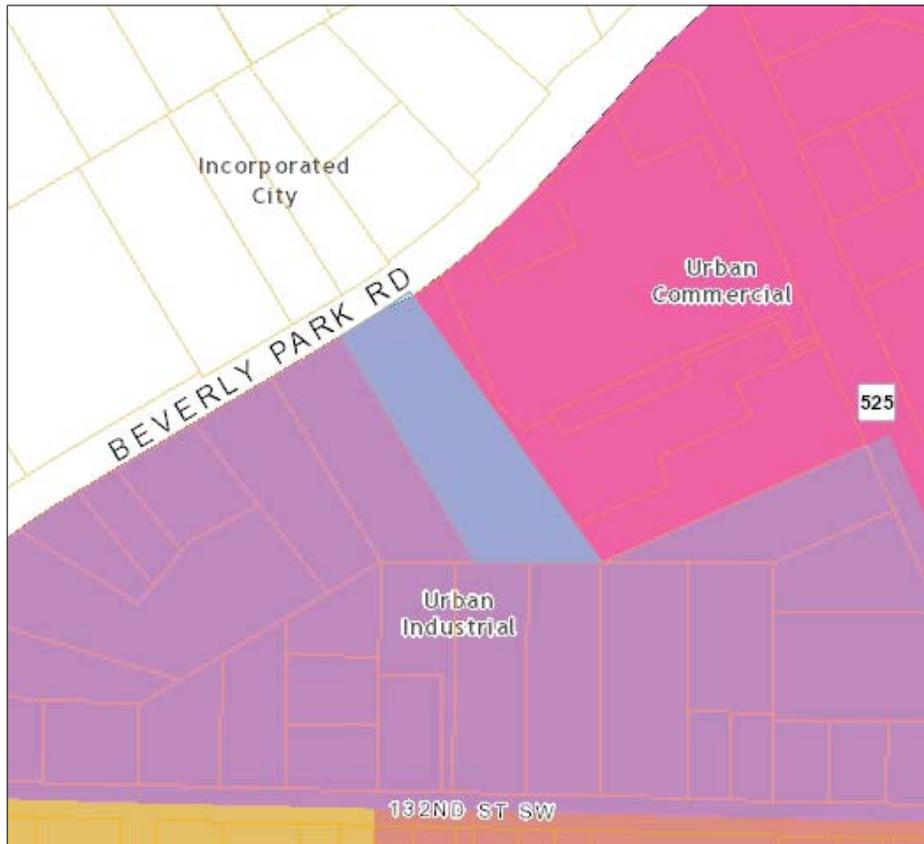
Parks (within 1/2 mile)

Schools (within 1/2 mile)

Bus Stops (within 1/2 mile)

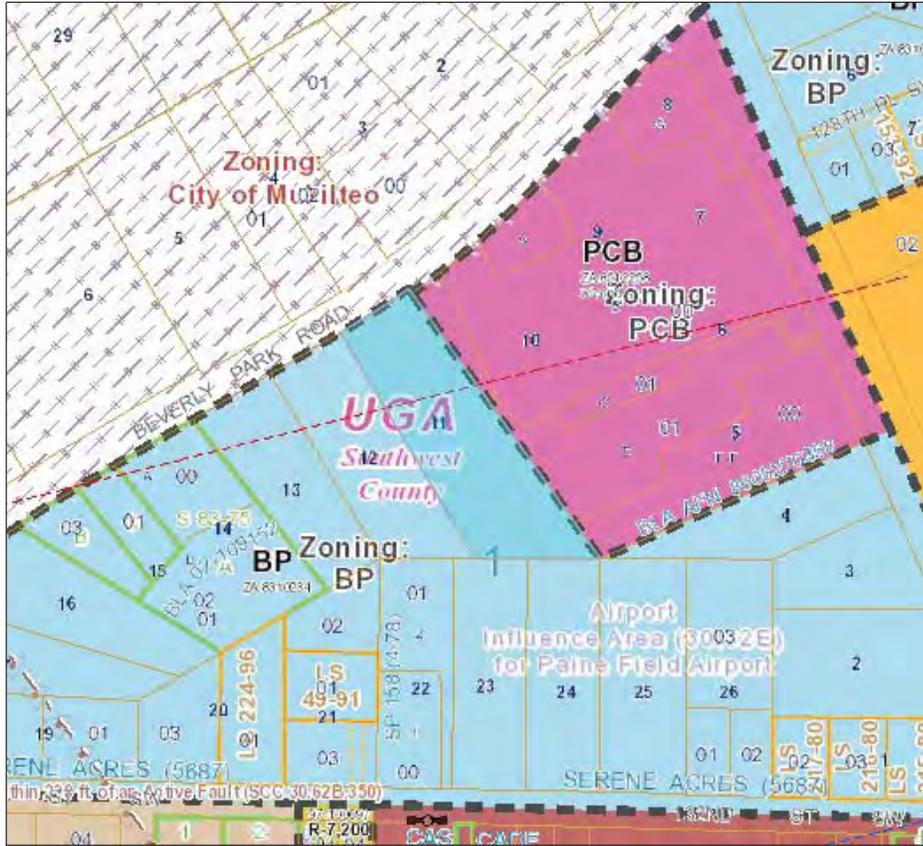
- Beverly Park Rd & 132nd St SW
- Beverly Park Rd & 134th Pl SW
- Beverly Park Rd & Hwy 525
- Hwy 525 & Beverly Park Rd
- Hwy 525 & Lincoln Wy
- Beverly Park Rd & Harbour Heights Rd
- Beverly Park Rd & Hwy 525
- Beverly Park Rd & 132nd St SW
- Hwy 525 & Beverly Park Rd
- Hwy 525 & Lincoln Wy

Future Land Use Map





Zoning Map





2015 Aerial Photo Map



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Planning and Development Services Property Report

About the Property Report

Report Generated On: 1/7/2019 10:21:58 AM

This report contains information regarding the subject property. This information may be useful for land developers, agents, and planners when analyzing potential land use changes.

The information in this report was compiled from the Snohomish County geographic information system (GIS). Data sources include several Snohomish County departments as well as federal, state, and local agencies.

Please note that all information contained in this report is subject to the disclaimer as noted at the bottom of each page and the end of the report.

Larger-sized map images are included at the end of this report.

Significant information that can affect permitting are displayed in **red text**.



General Location Info

Site Address:	12911 BEVERLY PARK RD
City:	LYNNWOOD
Zip:	98087-5127
Tax Parcel Number:	00568700101200
QTR-Sec-Twp-Rng:	SE 27 T28N R 4E : SW 27 T28N R 4E
Latitude / Longitude:	Lat=47.880365
<small>(NAD83)</small>	Long=-122.282243
WA State Plane North Zone:	X=1,284,897.89
<small>(NAD83, US Feet)</small>	Y=324,474.69
County Road Atlas Page:	123

Administrative Info

Land Use Jurisdiction:	City of Mukilteo : Snohomish County
Tribal Lands Status:	Non-tribal land
Tribal Lands Name:	Non-tribal land

All information contained in this report is subject to the [disclaimer](#) as noted on the final page.



Planning Info

Future Land Use (FLU):	CITY : UI
FLU Description:	Incorporated City : Urban Industrial
Zoning:	BP : CITY
Zoning Description:	Business Park : City
QTR-Sec-Twp-Rng:	SE 27 T28N R 4E : SW 27 T28N R 4E
Tax Parcel Number:	00568700101200
Urban Growth Area (UGA):	Southwest County UGA
Municipal UGA:	MUKILTEO : MUKILTEO MUGA
Transportation ILA:	Not in an Transportation Interlocal Agreement Area
TDR Sending Area:	Not in a TDR Sending area
TDR Receiving Area:	Not in a TDR Receiving area
Snow Load Factor:	0.049
Snow Load:	To obtain snow load value, turn on 'Snowload' layer in interactive map and click on the area of interest
No-Shooting Area:	Inside a No-shooting Area (SCC 10.12)
Lot Status:	Unconfirmed
SCC 30.23.040 (22) Applies:	Minimum Lot Size does not apply {per SCC 30.23.040(22)}
Transportation Services Area:	D
Mineral Resource Type:	Not in an Mineral Resource area
Mineral Resource Name:	Not in a mineral resource overlay area
Shoreline Management Area:	Not in a Shoreline Management Area



Planning and Development Services Property Report

Assessor Info

Tax Parcel: 00568700101200

Owner Name: TREE OWL PROPERTIES LLC

Taxpayer of Record: TREE OWL PROPERTIES LLC
(maintained by Treasurer)

Site Address: 12911 BEVERLY PARK RD
City: LYNNWOOD
Zip: 98087-5127

Use Code: 111 Single Family Residence - Detached

Gross Size (acres): 1.35

Land Value: \$688,100
Improvement Value: \$27,000

Total Value: \$715,100

Tax Year: 2018
Assessment Date: 01/01/2017

Property Account Summary: https://www.snoco.org/proptax/search.aspx?parcel_number=00568700101200

Permit Information: <http://www.snoco.org/app/pds/permitstatus/PDS-ParcelList.aspx?PN=00568700101200>



District Info

Council District:	County Council District 2 : County Council District 3
Fire District:	Fire District 01
Fire Authority:	South Sno. Co. Fire & Rescue Rfa
School District:	Mukilteo School District 6
Sewer District:	Not in a sewer district
Water District:	Alderwood Water And Wastewater District
Water Provider (CWSP):	Alderwood Water and Wastewater District
Park District:	Not in a park district
Park Service Area:	Nakeeta Beach
Drainage District:	Not in a drainage district
Diking District:	Not in a diking district
Flood Control District:	Not in a flood control district

Notification Info

Agriculture Notification Area:	Not within an agriculture notification area
Lahar Volcanic Notice (200 ft):	Not in a lahar hazard area
Commercial Forrest Notice (500 ft):	Not within 500 ft of a commercial forest
Mineral Resource Notice (2000 ft):	Not within 2,000 ft of a Mineral Resource Overlay area
Paine Field Airport:	Inside height restriction area (FAA Form 7460-1)
Airpark:	No airparks within 2500 ft
Airport Compatibility Area:	Paine Field Airport
Airport Influence Area:	Paine Field Airport



Critical and Physical Info

Watershed Name:	Cedar-Sammamish watershed
Aquifer Sensitivity:	Low Aquifer Sensitivity
Elevation: (NAVD88, US Feet)	Approximately 575.5 to 593.2 ft
Sub-basin Name:	Puget Sound Drainage sub-basin
Hydric Soils:	No hydric soils Hydric soils present
Basin Name:	Puget Sound
Flood Hazard Area:	Parcel is outside the flood hazard area
Sole Source Aquifer:	Not in a sole source aquifer
Water Resource Inventory Area:	WRIA 8
Flood Plain 100yr:	n/a
Critical Aquifer Recharge Area:	Not in a critical aquifer recharge area
Geology (erodible surface):	Vashon till
Soil Type:	ALDERWOOD-URBAN LAND COMPLEX, 2 TO 8 PERCENT SLOPES
National Wetlands Inventory:	No NWI wetlands present
Wetlands (Snoco):	No PDS wetlands present
Wetlands Last Edited:	No PDS wetlands present
Steep Slopes (> 33%):	Steep slopes not detected
Landslide Hazard Area:	Not within a known landslide and outside the modeled LHA area More Information: SCC 30.62B.340
Mine Hazard:	No mines within 200 feet
Pipelines:	No petroleum pipelines within 1,000 feet
Levees:	No levees within 1,000 feet
Levees Source:	No levee on the property
Data Compiled On:	01/06/2019



Planning and Development Services Property Report

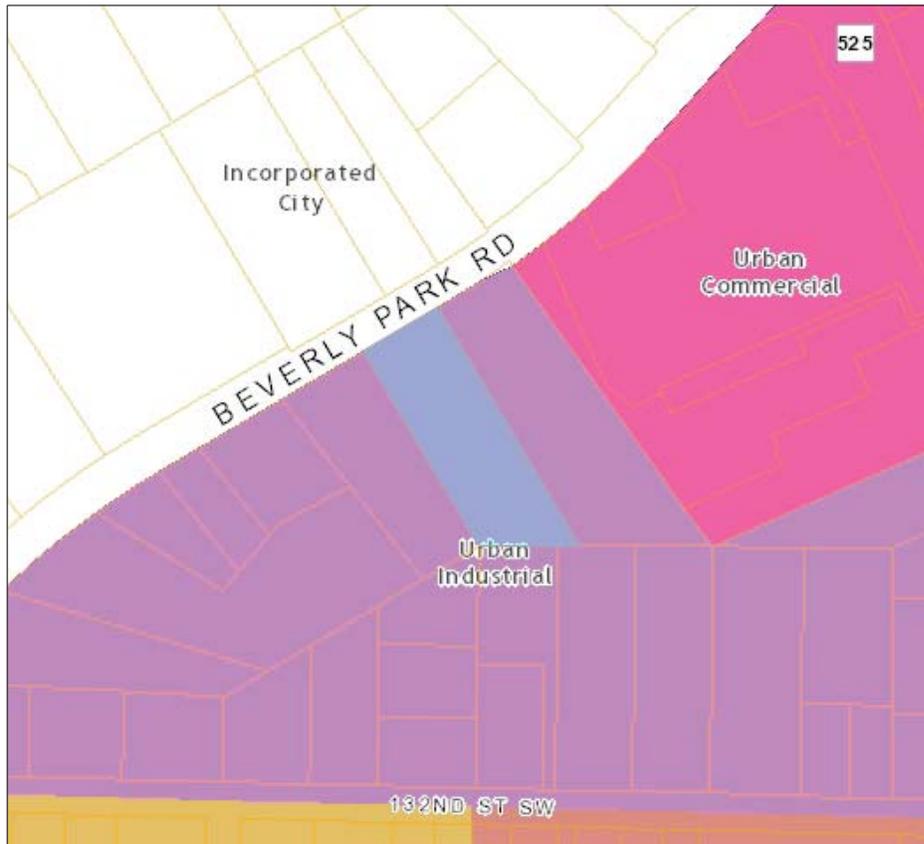
Parks (within 1/2 mile)

Schools (within 1/2 mile)

Bus Stops (within 1/2 mile)

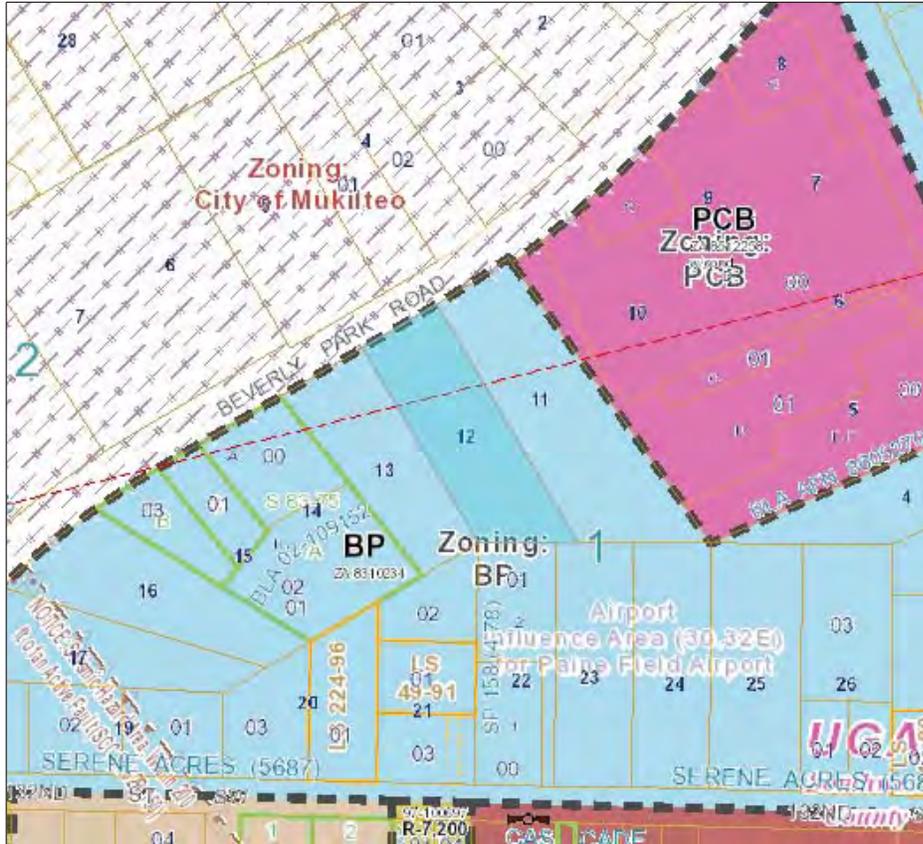
- Beverly Park Rd & 132nd St SW
- Beverly Park Rd & 134th Pl SW
- Beverly Park Rd & Hwy 525
- Hwy 525 & Beverly Park Rd
- Hwy 525 & Lincoln Wy
- Beverly Park Rd & Harbour Heights Rd
- Beverly Park Rd & Hwy 525
- Beverly Park Rd & 132nd St SW
- Hwy 525 & Beverly Park Rd
- Hwy 525 & Lincoln Wy

Future Land Use Map





Zoning Map





2015 Aerial Photo Map



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About the Property Report

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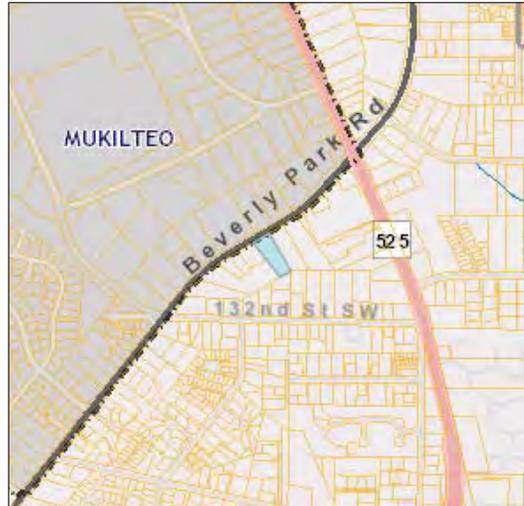
This report contains information regarding the subject property. This information may be useful for land developers, agents, and planners when analyzing potential land use changes.

The information in this report was compiled from the Snohomish County geographic information system (GIS). Data sources include several Snohomish County departments as well as federal, state, and local agencies.

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Larger-sized map images are included at the end of this report.

Significant information that can affect permitting are displayed in **red text**.



General Location Info

Site Address:	UNKNOWN UNKNOWN
City:	UNKNOWN
Zip:	No Data
Tax Parcel Number:	00568700101300
QTR-Sec-Twp-Rng:	SE 27 T28N R 4E : SW 27 T28N R 4E
Latitude / Longitude: (NAD83)	Lat=47.880242 Long=-122.282801
WA State Plane North Zone: (NAD83, US Feet)	X=1,284,760.32 Y=324,432.50
County Road Atlas Page:	123

Administrative Info

Land Use Jurisdiction:	City of Mukilteo : Snohomish County
Tribal Lands Status:	Non-tribal land
Tribal Lands Name:	Non-tribal land



Planning Info

Future Land Use (FLU):	CITY : UI
FLU Description:	Incorporated City : Urban Industrial
Zoning:	BP : CITY
Zoning Description:	Business Park : City
QTR-Sec-Twp-Rng:	SE 27 T28N R 4E : SW 27 T28N R 4E
Tax Parcel Number:	00568700101300
Urban Growth Area (UGA):	Southwest County UGA
Municipal UGA:	MUKILTEO : MUKILTEO MUGA
Transportation ILA:	Not in an Transportation Interlocal Agreement Area
TDR Sending Area:	Not in a TDR Sending area
TDR Receiving Area:	Not in a TDR Receiving area
Snow Load Factor:	0.049
Snow Load:	To obtain snow load value, turn on 'Snowload' layer in interactive map and click on the area of interest
No-Shooting Area:	Inside a No-shooting Area (SCC 10.12)
Lot Status:	Unconfirmed
SCC 30.23.040 (22) Applies:	Minimum Lot Size does not apply {per SCC 30.23.040(22)}
Transportation Services Area:	D
Mineral Resource Type:	Not in an Mineral Resource area
Mineral Resource Name:	Not in a mineral resource overlay area
Shoreline Management Area:	Not in a Shoreline Management Area



Planning and Development Services Property Report

Assessor Info

Tax Parcel: 00568700101300

Owner Name: TREE OWL PROPERTIES LLC

Taxpayer of Record: TREE OWL PROPERTIES LLC
(maintained by Treasurer)

Site Address: UNKNOWN UNKNOWN
City: UNKNOWN
Zip: No Data

Use Code: 910 Undeveloped (Vacant) Land

Gross Size (acres): 1.13

Land Value: \$577,400
Improvement Value: \$0

Total Value: \$577,400

Tax Year: 2018
Assessment Date: 01/01/2017

Property Account Summary: https://www.snoco.org/proptax/search.aspx?parcel_number=00568700101300

Permit Information: <http://www.snoco.org/app/pds/permitstatus/PDS-ParcelList.aspx?PN=00568700101300>



Planning and Development Services Property Report

District Info

Council District:	County Council District 2 : County Council District 3
Fire District:	Fire District 01
Fire Authority:	South Sno. Co. Fire & Rescue Rfa
School District:	Mukilteo School District 6
Sewer District:	Not in a sewer district
Water District:	Alderwood Water And Wastewater District
Water Provider (CWSP):	Alderwood Water and Wastewater District
Park District:	Not in a park district
Park Service Area:	Nakeeta Beach
Drainage District:	Not in a drainage district
Diking District:	Not in a diking district
Flood Control District:	Not in a flood control district

Notification Info

Agriculture Notification Area:	Not within an agriculture notification area
Lahar Volcanic Notice (200 ft):	Not in a lahar hazard area
Commercial Forrest Notice (500 ft):	Not within 500 ft of a commercial forest
Mineral Resource Notice (2000 ft):	Not within 2,000 ft of a Mineral Resource Overlay area
Paine Field Airport:	Inside height restriction area (FAA Form 7460-1)
Airpark:	No airparks within 2500 ft
Airport Compatibility Area:	Paine Field Airport
Airport Influence Area:	Paine Field Airport



Critical and Physical Info

Watershed Name:	Cedar-Sammamish watershed
Aquifer Sensitivity:	Low Aquifer Sensitivity
Elevation: (NAVD88, US Feet)	Approximately 579.0 to 594.3 ft
Sub-basin Name:	Puget Sound Drainage sub-basin
Hydric Soils:	No hydric soils Hydric soils present
Basin Name:	Puget Sound
Flood Hazard Area:	Parcel is outside the flood hazard area
Sole Source Aquifer:	Not in a sole source aquifer
Water Resource Inventory Area:	WRIA 8
Flood Plain 100yr:	n/a
Critical Aquifer Recharge Area:	Not in a critical aquifer recharge area
Geology (erodible surface):	Vashon till
Soil Type:	ALDERWOOD-URBAN LAND COMPLEX, 2 TO 8 PERCENT SLOPES
National Wetlands Inventory:	No NWI wetlands present
Wetlands (Snoco):	No PDS wetlands present
Wetlands Last Edited:	No PDS wetlands present
Steep Slopes (> 33%):	Steep slopes not detected
Landslide Hazard Area:	Not within a known landslide and outside the modeled LHA area More Information: SCC 30.62B.340
Mine Hazard:	No mines within 200 feet
Pipelines:	No petroleum pipelines within 1,000 feet
Levees:	No levees within 1,000 feet
Levees Source:	No levee on the property
Data Compiled On:	01/06/2019



Planning and Development Services Property Report

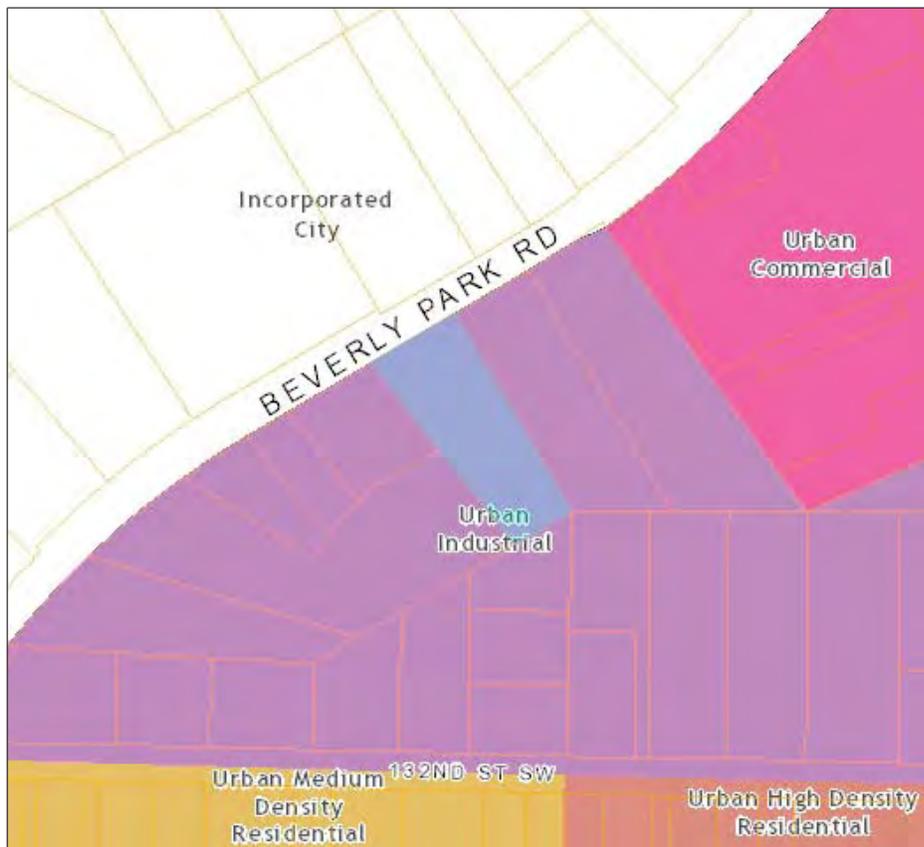
Parks (within 1/2 mile)

Schools (within 1/2 mile)

Bus Stops (within 1/2 mile)

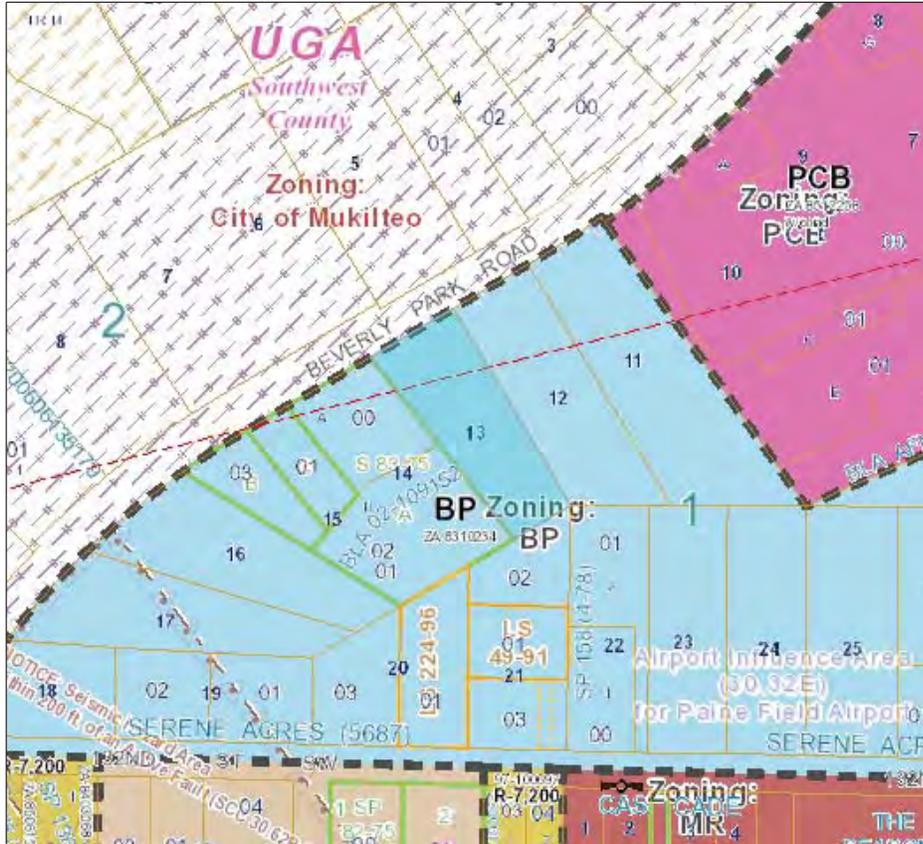
- Beverly Park Rd & 132nd St SW
- Beverly Park Rd & 134th Pl SW
- Beverly Park Rd & Hwy 525
- Hwy 525 & Beverly Park Rd
- Hwy 525 & Lincoln Wy
- Beverly Park Rd & Harbour Heights Rd
- Beverly Park Rd & Hwy 525
- Beverly Park Rd & 132nd St SW
- Hwy 525 & Beverly Park Rd

Future Land Use Map



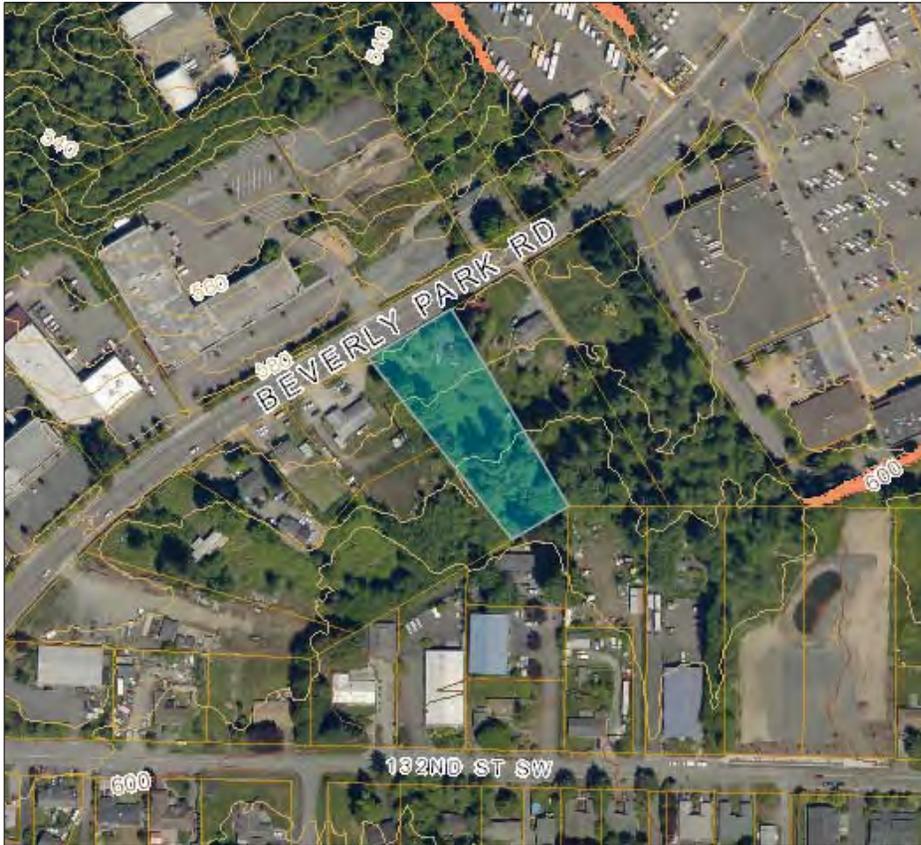


Zoning Map





2015 Aerial Photo Map



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Exhibit 13

Kindred Healthcare 2018 Quality Report

2018 Quality Report

**Delivering Solutions
for Medically
Complex and
Rehab-Intensive
Patients Through
Partnerships,
Innovation and
Quality**





Unique Patients

Innovation

Partnerships

Quality



Committed to Doing the Right Thing for Our Patients, People and Partners and Delivering Quality Every Day

I am proud to share Kindred Healthcare's 11th Annual Quality Report. 2018 was a truly transformative year for Kindred, as we restructured our Company to reflect the challenging and changing dynamics of the healthcare system. In 2018, we reorganized into two separate specialty healthcare companies: Kindred at Home, focused on supportive care delivered in home settings; and Kindred Healthcare, a specialty hospital company focused on providing care to the nation's most medically complex and rehab-intensive patients in our Long-Term Acute Care (LTAC) Hospital and Inpatient Rehabilitation Hospital settings.

The new Kindred Healthcare that is the subject of this Report plays a vital role in our healthcare ecosystem as the nation's leading specialty hospital and rehabilitation provider. We focus on treating the most medically complex and rehab-intensive patients—the 10% subset of patients who account for over 60% of healthcare costs. Without our care these patients fall through the cracks in an otherwise disjointed healthcare system. We provide solutions for this unique subset of patients through our partnerships with hospitals, payers and other providers in the healthcare continuum. And we deliver compassionate care in a culture steeped in innovation, with a relentless focus on quality. As summarized in this 2018 Quality Report, our unique approach to care results in quality outcomes that exceed national benchmarks, reduced hospital readmissions, lower costs, and ultimately, a more positive patient experience.

This Report describes the great care and patient experience we delivered in 2018, but also shows how we are driving innovation for the unique patient population we serve. To name just a few exciting initiatives:

- **Technology Solutions** – Kindred partnered with Netsmart, a leading healthcare technology solutions company to create and deploy cutting edge electronic health records in all of our care settings. Through these technology solutions we will be able to connect seamlessly with our partners across the care continuum and to leverage advanced analytics to make care more effective and efficient.
- **Patient Engagement** – We launched RehabTracker, a proprietary patient engagement app that enables real-time communication between patients, the clinical team and loved ones. This application has already resulted in measurable improvements in outcomes for patients as well as improvements in patient and family experience.
- **Partnerships** – Kindred has 20 Joint Venture partnerships for Inpatient Rehabilitation Hospital services with some of the nation's leading academic and non-profit hospital systems. In 2018, we

entered into three definitive agreements to partner with additional systems to expand our unique brand of care for the growing population of patients in need of intensive rehabilitation services. Kindred's partnership model leverages the strengths of both the acute and post-acute systems and creates a seamless continuity of care for this unique population.

- **Care Management/Transitions of Care** – In 2018, Kindred formed Lacuna Health, a subsidiary focused on partnering with ACOs, physicians and providers across the post-acute continuum to help manage patients' transitions from hospital to home and to bridge gaps in care. Lacuna's nurses maintain connection with patients discharged to home not only to ensure smooth transitions but to identify care needs to avoid costly hospital readmissions and to maintain independence at home. In 2018, Lacuna engaged with over 230,000 patients and their families.

Of course, our 35,700 dedicated employees of Kindred Healthcare are at the core of what we do each day. Last year, they worked together to build on our record of outperforming national benchmarks in key quality metrics, leveraged new technologies to better serve our patients and make recovery possible, and created innovative solutions on behalf of our patients, partners and payers.

Improving the lives of patients is what we do, and to us, that means more than treating their medical conditions. This is why we have fostered a culture of giving – supporting health, cultural and educational institutions that make a positive impact every day. In 2018, through the Kindred Foundation, we again invested in and matched employee donations to organizations that are committed to improving the communities in which we live, work and serve, including the American Heart Association, the American Lung Association and the American Stroke Association. We do so to improve the communities in which our patients and our teammates live.

On behalf of our dedicated and talented people, I thank you for letting us share some of the ways in which we are improving recovery and wellness.



Benjamin A. Breier
President and Chief Executive Officer
Kindred Healthcare

Quality Outcomes – the Foundation for Exceptional Patient Care and Recovery

Achieving High-Quality Performance...

In 2018, our LTAC Hospitals improved patient ventilator wean rates to 67%.

Kindred's Acute Rehabilitation Units and freestanding Inpatient Rehabilitation Hospitals outperformed national benchmarks with fewer patient rehospitalizations and shorter lengths of stay than our peers.

In 2018, RehabCare therapists significantly improved patients' functional outcome measures in partner nursing centers.

In 2018, our LTAC Hospitals had low hospital readmission rates of 8.6%.

In partnership with Netsmart, we will deploy state-of-the-art, fully interoperable electronic health records in all of our settings to improve care outcomes and address gaps in patient care.

...To Improve the Patient Experience and...

In 2018, RehabTracker – our clinical and patient engagement app – provided a proven increase in quality metrics in participating facilities.

Over 11,000 patients to date have benefited from RehabTracker patient engagement app.

In 2018, the percentage of patients who are "likely to recommend" Kindred Hospitals improved by 11%.

Lacuna Health assisted approximately 230,000 patients and their families in navigating a disjointed post-acute care system in 2018.

...To Make Recovery Possible.

In 2018, RehabCare delivered therapy to more than 430,600 patients, aiding in their recovery and return to home.

Upon discharge from RehabCare, patients regained 81.9% of the function that they had prior to injury or illness that necessitated the therapy services.

Lacuna Health's nurse-led teams helped identify more than 45,000 clinical needs post-discharge in 2018.

Our freestanding Inpatient Rehabilitation Facilities successfully discharged 79% of patients back to their home or community in 2018 and created much greater improvement in function than national benchmarks.



OUR VISION

Patients reach their highest potential for health and healing.

OUR MISSION

To help our patients reach their highest potential for health and healing with intensive medical and rehabilitative care through a compassionate patient experience.

Kindred Is

35,700 dedicated teammates taking care of more than

450,000 people in

1,800

hospitals and health facilities in

45 states.

Kindred Hospitals

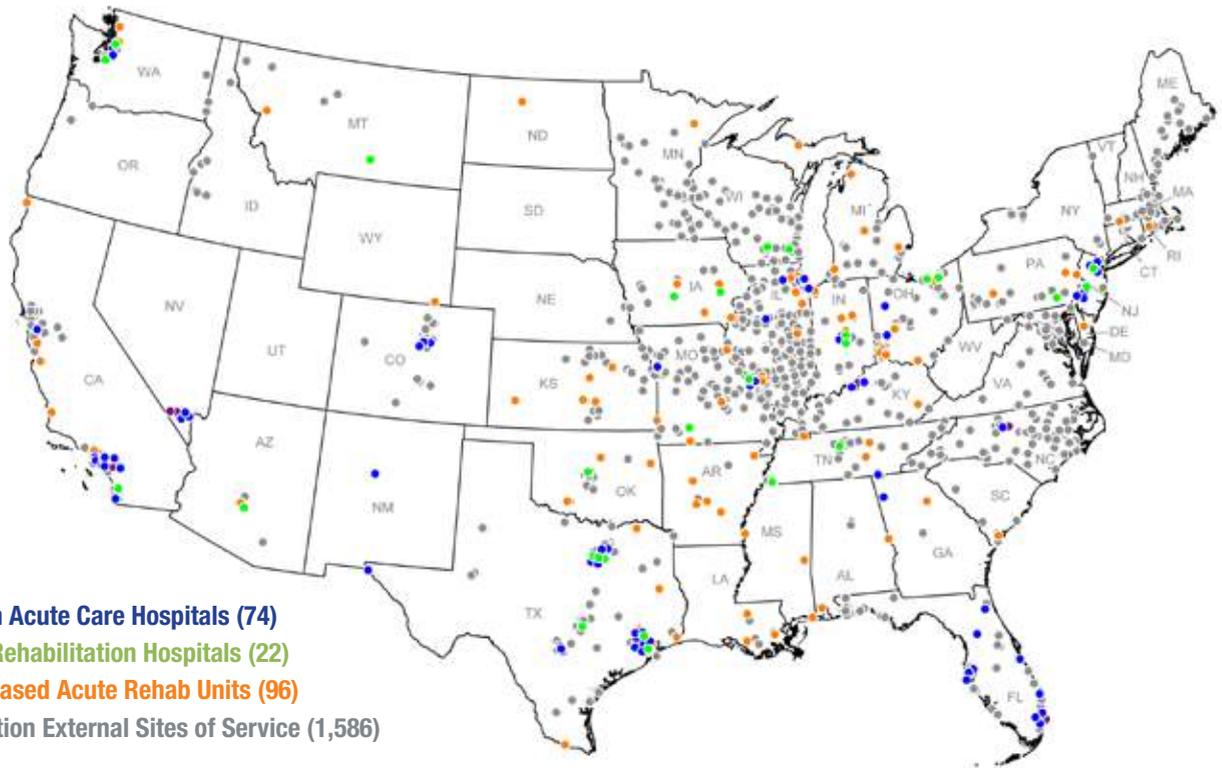
Patients in Kindred Hospitals (certified as long-term acute care hospitals) are among the sickest in the nation. Our patients are critically and chronically ill with multiple comorbidities requiring the specialized care and extended recovery time they need to reach their full potential.

Our hospitals feature physician-led interdisciplinary teams, 24/7 ICU/CCU-level clinical care and specially trained staff who help drive improved outcomes and reduce costly readmissions. With staffing that offers three times the resources per patient than skilled nursing facilities (SNFs) and expertise in the most medically complex patient population, our readmission rate is only 8.6%, compared to 24% from SNFs.

Inpatient Rehabilitation

For patients with the greatest rehabilitation needs, Inpatient Rehabilitation Facilities (IRFs) – often referred to as Inpatient Rehabilitation Hospitals – provide the intensive, interdisciplinary clinical and rehabilitation services necessary for improved function and independence.

We also specialize in care for patients with increasingly more complex needs. These patients are often recovering from stroke, spinal cord injury, brain injuries and other neurological conditions. Our clinicians deliver a sophisticated level of care that isn't available in other settings, such as SNFs, assisted living centers or through home health.



Long-Term Acute Care Hospitals (74)
Inpatient Rehabilitation Hospitals (22)
Hospital-Based Acute Rehab Units (96)
 Rehabilitation External Sites of Service (1,586)

RehabCare

RehabCare is the nation’s premier provider of contract rehabilitation services with more than 9,000 therapists delivering medically necessary rehabilitation therapies to patients in nearly 1,600 healthcare settings.

Our partners face a variety of challenges in providing rehabilitative services both clinically and from a management perspective. We work with our partners to help navigate everything from compliance to staffing to reimbursement challenges. We’ve also developed specialty clinical programs to improve function while supporting the highest quality of life possible.

Lacuna Health

Lacuna Health is a clinical engagement company with a mission to fill gaps and improve care for patients. Through contact center, transition of care and physician practice solutions, Lacuna Health currently partners with hospitals, university health systems, physicians, post-acute care providers and accountable care organizations (ACOs) to improve the continuity of care.

Built on the experience of its 24/7 RN-led contact center and intelligent technology, Lacuna extends the reach and effectiveness of its partners across the continuum.



A Unique Patient Population Demands Care Solutions

Aging Population with Unique Care Needs

Our nation is facing a wave of aging Americans with new and increasing healthcare needs. The numbers are quite striking – by 2030, there will be more than 80 million Americans 65 or older – up from 56 million today. Not only is there a larger aging population, they are also sicker, with more than 66 percent of Medicare beneficiaries having two or more chronic conditions that are very difficult and costly to care for. A recent report by the nonpartisan Congressional Budget Office (CBO) stated that “while the sheer number of older adults is rising, so too is the cost of their healthcare as individuals are more frequently living with multiple chronic and complex medical conditions.”

In fact, only 10 percent of all Medicare beneficiaries account for 60 percent of the program’s annual costs. These are the very patients that Kindred specializes in treating – the most medically complex, costly patients that require specialized care at a lower cost.

Kindred Healthcare Is Delivering Innovative Solutions

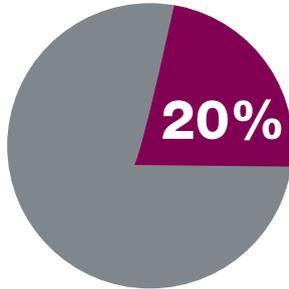
In order to best meet patient need and deliver exceptional medical and rehabilitative care that supports recovery and return to home, Kindred has significantly expanded its care management capabilities, developed a groundbreaking technology-driven clinical platform and implemented new strategic partnerships across the continuum.

Addressing the growing demand for value-based care, we have put key resources in place to help consumers navigate a confusing system. This also helps ensure patients receive the right care for the right duration with targeted clinical interventions to support shorter lengths of stay, prevent rehospitalizations and bolster ongoing wellness.



America is aging rapidly...

By 2029, Medicare beneficiaries will account for more than 20% of the nation's population.



US Census: The Baby Boom Cohort in the United States: 2012 to 2060, May 2014

... and in turn getting sicker.

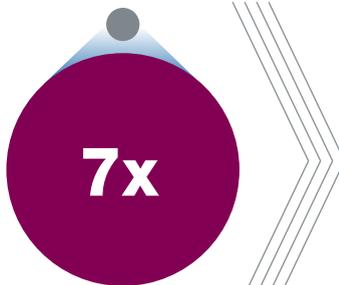
14% of Medicare beneficiaries have chronic conditions



CMS: Chronic Conditions Among Medicare Beneficiaries, 2012 Chartbook

Higher acuity brings clinical and cost challenges.

Patients with multiple chronic conditions cost up to seven times as much as patients with only one chronic condition.



Erdem, Erkan et al, Medicare Payments: How Much Do Chronic Conditions Matter?, Medicare & Medicaid Research Review 2013: Volume 3, Number 2

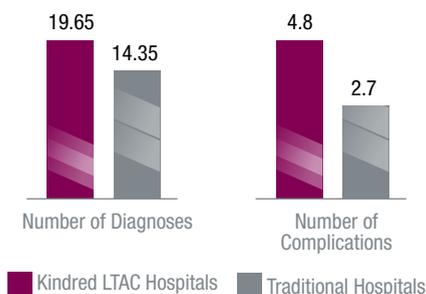
10% of Medicare beneficiaries – the most chronic and medically complex patients – consume 60% of annual costs



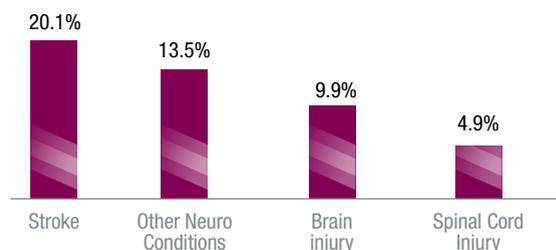
MedPAC 2018 Data Book: Healthcare Spending and the Medicare Program

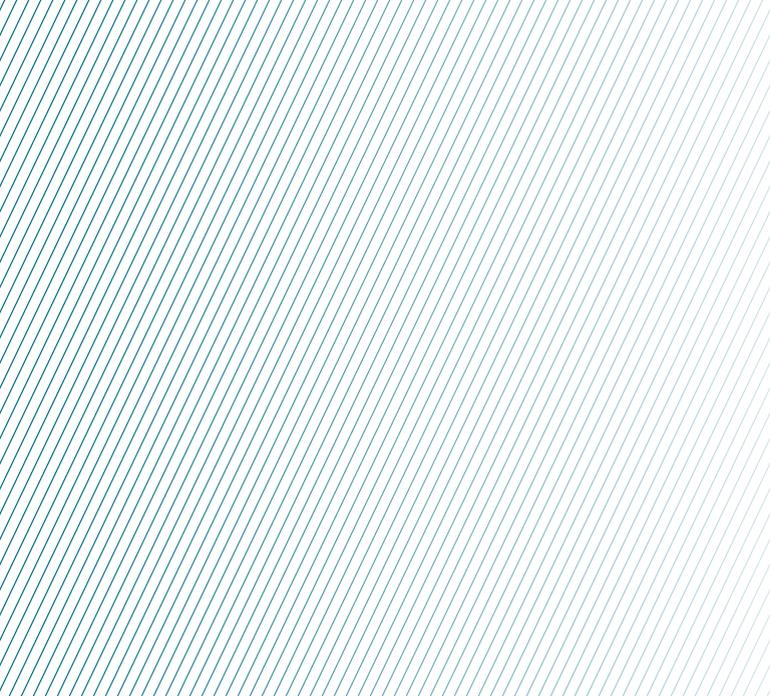
Kindred specializes in caring for these patients while actively improving outcomes and reducing costs.

Kindred LTAC Hospital Patients are Sicker than Those in Traditional Hospitals



Kindred Inpatient Rehabilitation Hospitals are Caring for More Medically Intensive Patients





A Post-Acute Care Solution for Hospital Systems

Kindred's specialty hospital and contract rehabilitation presence in local markets nationwide – complemented by its key capabilities of care coordination, data analytics to predict the optimal patient discharge setting and tools that follow and support a patient on an ongoing basis – helps hospital systems develop high-performing post-acute networks, efficiently manage patients and appropriately navigate associated risks. Kindred's positive partnerships with hospital systems are helping to advance integrated care and expand the reach of the hospital far beyond its four walls. This is especially true for the most clinically complex and difficult-to-treat patients.

Delivering Solutions to Payers for the Most Costly and Difficult-to-Treat Patients

At the same time that health providers are experiencing new risk-based payment models, payers are demanding higher-quality clinical outcomes, shorter lengths of stay and lower rates of rehospitalizations. Kindred offers payers effective solutions for the most difficult-to-treat post-acute patients with our platform, which manages costly, medically complex and chronically ill populations.

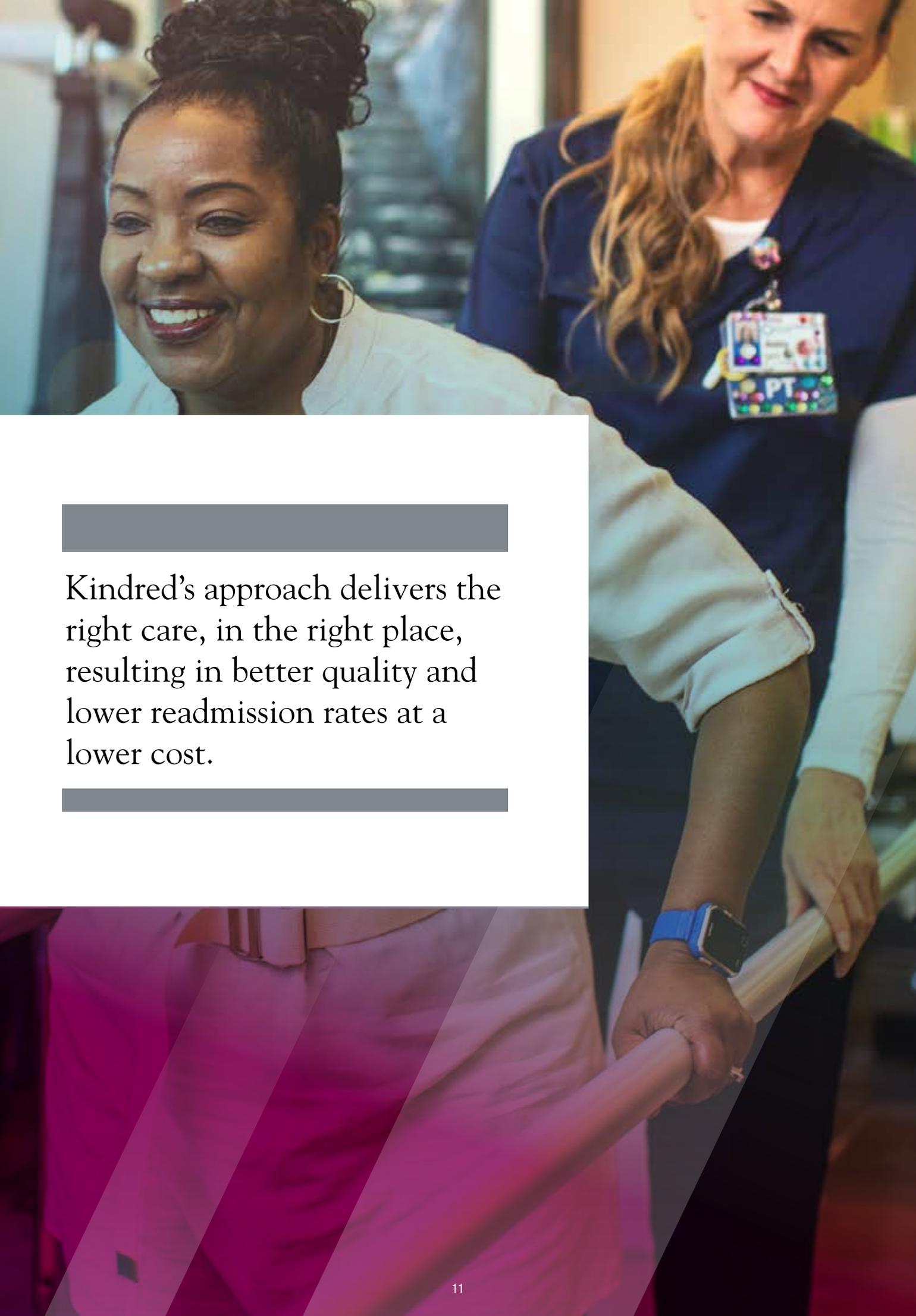
Providing the right care in the right place allows us to create care models that support wellness and prevent the need for a hospital admission. Transition management and post-discharge patient support further enables Kindred to deliver population health and integrated care management.



“Medicare can cut 5% to 10% of its total spending if it focuses on chronic disease prevention and coordinated care for those with chronic conditions.”

Ken Thorpe, PhD, health policy professor at Emory University in Atlanta, 2012





Kindred's approach delivers the right care, in the right place, resulting in better quality and lower readmission rates at a lower cost.

Partnerships to Improve Patient Care

Partnerships Powering Improved Outcomes and Engagement

As part of Kindred's response to the rapidly evolving healthcare environment, we are building robust alliances to support effective care coordination and improved clinical outcomes across the continuum. Strong partnerships, joint venture agreements and clinical collaborations position Kindred Healthcare to deliver comprehensive post-acute solutions that patients, hospitals, health systems and payers need.

Joint Ventures

Kindred continues to forge joint venture partnerships with some of the nation's leading health systems and universities to drive efficiencies and clinical integration in inpatient rehabilitation hospitals,

transitional care hospitals and care management. These partnerships continue to produce strong quality performance with optimal clinical outcomes.

Accountable Care Organizations (ACOs)

Kindred LTAC Hospitals and IRFs are preferred providers in many hospital-led ACOs nationally. In addition, Kindred is an owner and strategic partner in the Silver State ACO, which covers approximately 25,000 lives and 44 physician practices representing 270 physicians across the state of Nevada. The Centers for Medicare & Medicaid Services (CMS) announced in late 2017 that this ACO was among the 31% of U.S. Medicare Shared Savings ACOs that earned shared savings – and the only one in Nevada.

Kindred Healthcare is partnering with leading hospitals and health systems around the country to improve care and reduce costs.



For the second year, in 2017, Silver State earned savings for the 2016 performance year of over \$15 million and its quality scores increased to 88.6%.

Medicare Advantage (MA) Partnerships

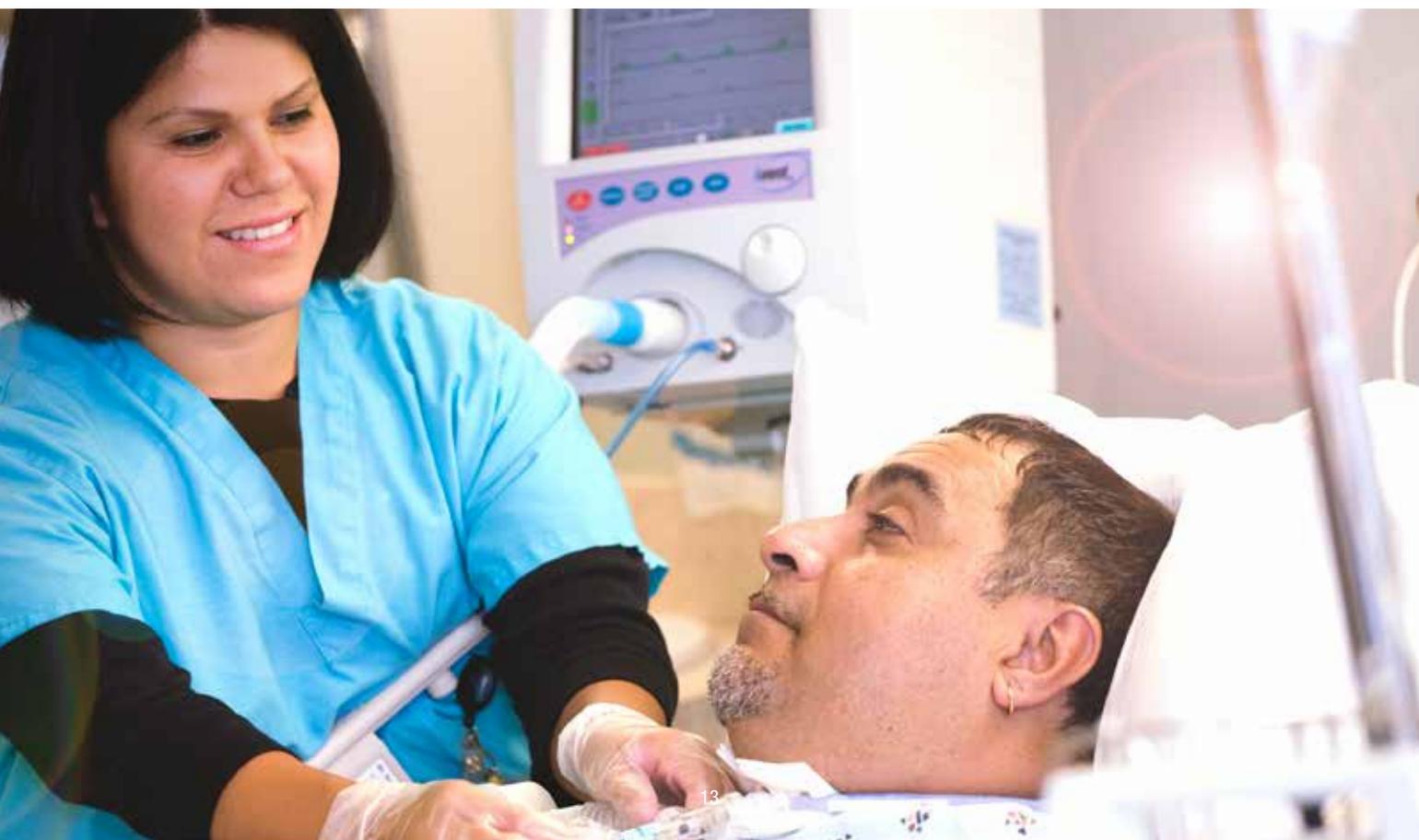
Kindred has also forged partnerships with managed care and Medicare Advantage plans to help manage the most medically complex populations and offer value through:

- **Lower cost of care** – The average cost per day at an LTAC hospital is between 25 - 55% lower than at a traditional hospital.
- **Specialized clinical capabilities** – ICU, diagnostic capabilities and diverse physician specialists help manage patients with high acute needs.
- **Reduced acute care length of stay** – Decreasing acute care bed days by earlier transitions of patients to LTAC hospitals.
- **Optimal patient outcomes** – In 2018, Kindred LTAC hospitals in California discharged more than 55% of MA patients to a lower level of care, including home.

Kindred recently entered into an early-stage, value-based contract with Humana, the nation's largest Medicare Advantage plan. This arrangement includes graduated per diems by length of stay for medically complex patients. In 2018, Kindred experienced a 44% increase in medically complex Humana patients treated.

“Kindred has been a valuable partner to our Medicare Advantage Plan by taking care of our most vulnerable patients. The Kindred model has been ideal for us in managed care, but should be an example for patient care in all populations.”

Osmundo Saguil, MD, FACP, Medical Director, Desert Oasis Healthcare, A Medicare Advantage Plan





Investing in Innovations to Improve Patient Care and Reduce Costs

Unique Partnership to Innovate EMR Solutions

In 2018, Kindred and Netsmart combined teams from both organizations to create a state-of-the-art electronic, integrated clinical record platform. This leading edge electronic medical record system will feature advanced analytics, which will serve to improve quality outcomes and facility efficiency. Additionally, it will be fully interoperable with our partners' electronic record systems. Together, Kindred and Netsmart will rapidly expand the functionality of Kindred's existing proprietary medical records solutions to address needs in information exchange and care coordination across a fully integrated specialty care platform. This includes Kindred's LTAC Hospitals, Inpatient Rehabilitation Hospitals and Lacuna Health's care engagement solutions.



In 2018, RehabTracker – our clinical and patient engagement app – provided a proven increase in quality metrics in participating facilities.

Patient Engagement Technology

The latest patient engagement offering from Kindred Rehabilitation Services – the RehabTracker app – is another example of our ability to provide innovative solutions to our patients and partners. RehabTracker allows patients to set goals with their therapists, track their progress, share their results with invited family and friends and even receive messages of support – all at the touch of a button. It also gives our partners access to innovative tools without the heavy lift and burden of creating their own application. This patient engagement tool has been deployed in Kindred freestanding rehab hospitals, acute rehabilitation units and LTAC hospitals, and is being tested in partner skilled nursing facilities.

Applying Groundbreaking Technologies for Optimal Patient Outcomes

Kindred Rehabilitation Services is the nation’s largest user of the Ekso GT, an innovative, wearable robotic “exoskeleton” designed to help patients who are

living with stroke or spinal cord injuries improve gait training. The Ekso GT is approved by the U.S. Food and Drug Administration (FDA) for clinic use as it promotes early mobility and uses muscle stimulation to maximize mobility and function for a broad range of patients.

Partnering with Universities to Drive Technological Innovation

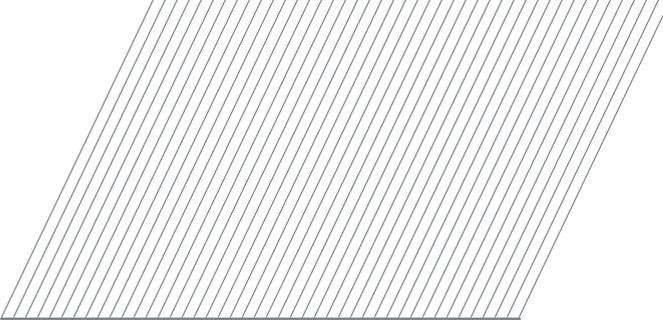
Kindred and the University of Louisville’s Speed School of Engineering formed an innovative partnership, called HIVE, focused on creating healthcare technology solutions that improve the lives and the delivery of services for an aging population. At the site, Kindred employees work with students and faculty from the school to develop apps that will improve care and lower costs.





Kindred Hospitals

Online reviews for Kindred Hospitals increased by more than 16% as compared to the previous year, with 92% of all reviews being positive. Our hospitals earned an average rating of 4.6 out of 5 stars from thousands of reviews.



“For patients recovering from severe acute illness, admission to a long-term acute care hospital is an increasingly common alternative to continued management in an intensive care unit.”

Jeremy Kahn et al, “Effectiveness of long-term acute care hospitalization in elderly patients with chronic critical illness.” Med Care. 2013 Jan;51(1):4-10



Patient-Centered Interdisciplinary Care

In order to treat patients with an acute diagnosis on top of multiple chronic illnesses, multi-organ system failure, or who require a lengthy reliance on a ventilator, we have established clinical programs, condition-specific pathways and outcome measures to support optimal clinical recovery. Our physician-led interdisciplinary teams coordinate all aspects of specialty care for the nation’s sickest patients (1% of Medicare beneficiaries) to save lives, improve clinical outcomes and make recovery possible.

Disease-Specific Certifications Setting Kindred Hospitals Apart

Kindred Hospitals have attained advanced-level certification – Disease-Specific Care (DSC) Certification – by The Joint Commission to further develop expertise and best practices in caring for the most difficult-to-treat patients. In 2018, several Kindred LTAC hospitals received DSC Certification

in two disease areas that most affect our patients – respiratory failure and pulmonary rehabilitation – with a goal of having all hospitals achieve this advanced-level certification. Pursuing this DSC Certification represents our commitment to find new and innovative ways to improve the quality of patient care, improve our culture of care and continuously improve the level of expertise of our dedicated clinicians.

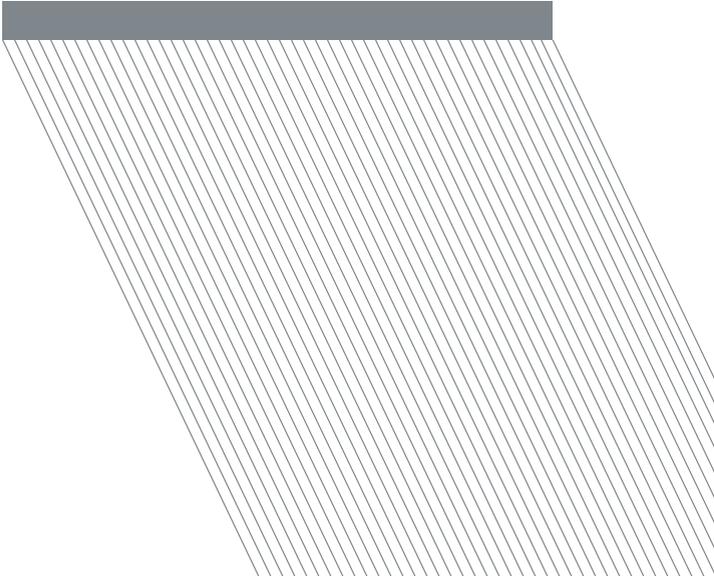
Post-Transplant Care

Patients receiving organ transplants often need additional specialized care and rehabilitation to facilitate full recovery. Kindred’s interdisciplinary teams coordinate closely with the patient’s transplant team at the referring hospital to support optimal recovery. Our hospitals commonly treat patients after successful liver, kidney, lung or heart organ transplants.

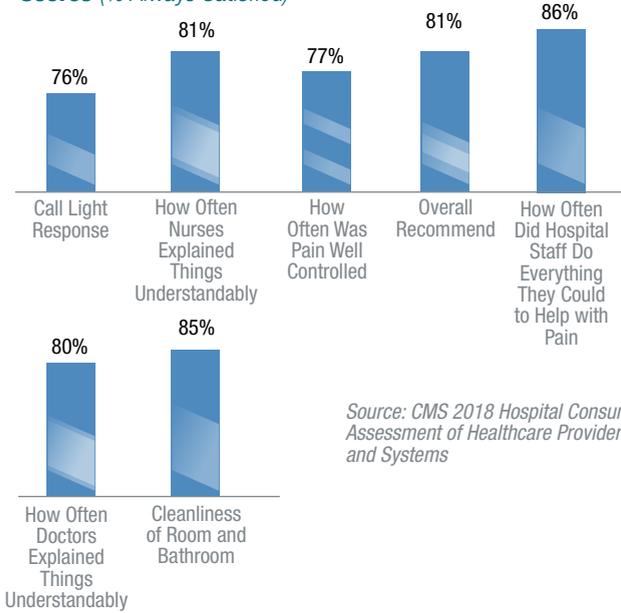


In 2017, patients were **21%** more likely to be rehospitalized during a SNF stay than during an LTAC hospital stay.

Analysis of MedPAC presentation of 2017 CMS data

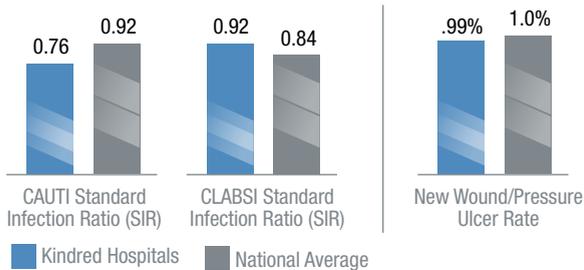


Kindred 2018 LTAC Hospital Patient/Family Satisfaction Scores (% Always Satisfied)



Source: CMS 2018 Hospital Consumer Assessment of Healthcare Providers and Systems

Kindred 2018 LTAC Hospital Quality Indicators*

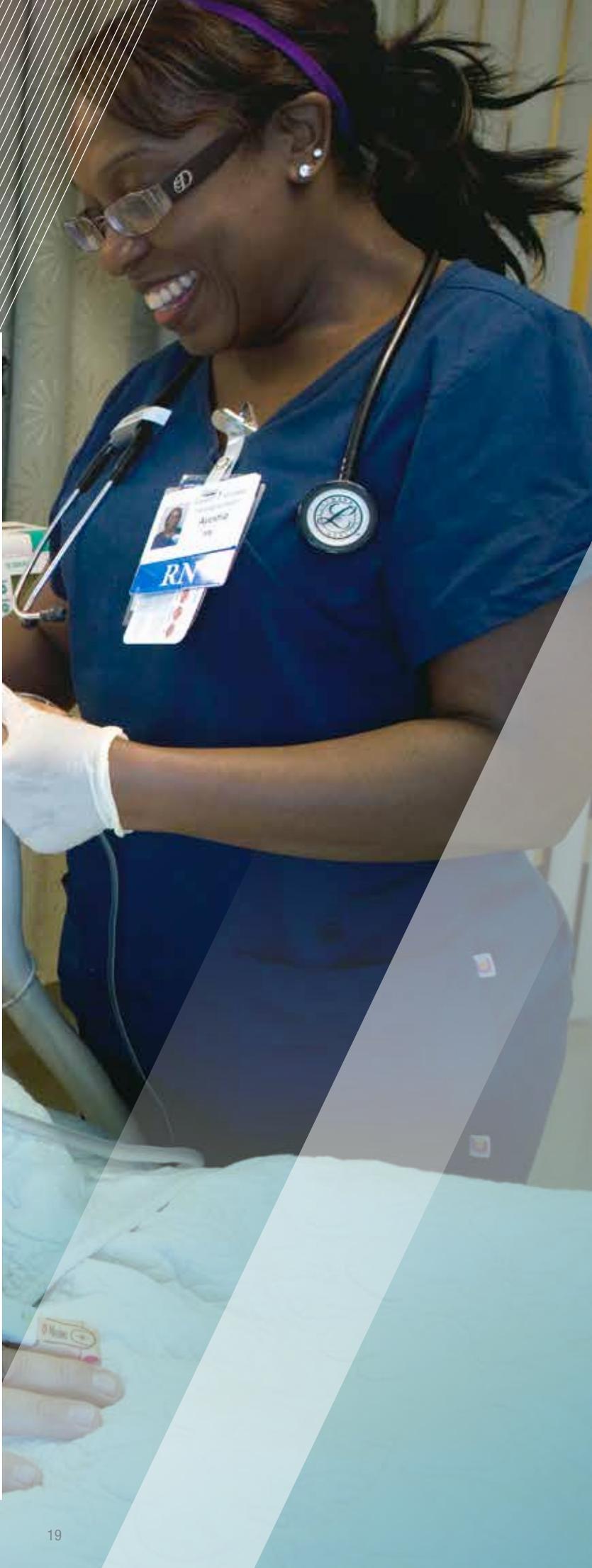


*Lower is better

Source: Kindred Internal Data

Kindred Hospitals have improved ventilator wean rates to **67%** and have a 30-day readmission rate of just **8.6%**.





Investing in Technology and State-of-the-Art Equipment that Improves Lives

For patients who require extended recovery times, a hospital bed is critical to avoid skin breakdown, falls and to improve function. We have invested in refitting our hospitals with state-of-the-art beds from Arjo, a leading bed manufacturer, that will help to improve the outcomes of our patients and help our caregivers deliver on their promise of quality care.

The patented technology in these beds' surfaces offers help to patients with wounds ranging from stage I to stage IV. Our new beds also have the ability to put patients into an upright chair position, to encourage movement as early in their recovery as possible. The ability to start getting our patients to an upright position only helps that process. Additionally helpful in these efforts is the bed's ability to get low to the ground to ease patients' ability to stand up out of the bed.

These beds aren't only better for our patients but better for our caregivers, making patient interactions easier and safer.





For patients with the greatest rehabilitation needs, Inpatient Rehabilitation Facilities (IRFs) – certified as hospitals and sometimes referred to as Rehabilitation Hospitals – provide the intensive, interdisciplinary clinical and rehabilitation services necessary for improved function and independence. Patients must be able to participate in at least three hours of therapies each day, five days a week under the direction of a doctor specialized in rehabilitation and physical medicine, a physiatrist and 24/7 nursing care.

Patient-Centered Clinical Programming

We improve care quality using interdisciplinary patient-centered clinical programs, identifying the most appropriate patients for the right program, and leading them to their optimal outcomes. These

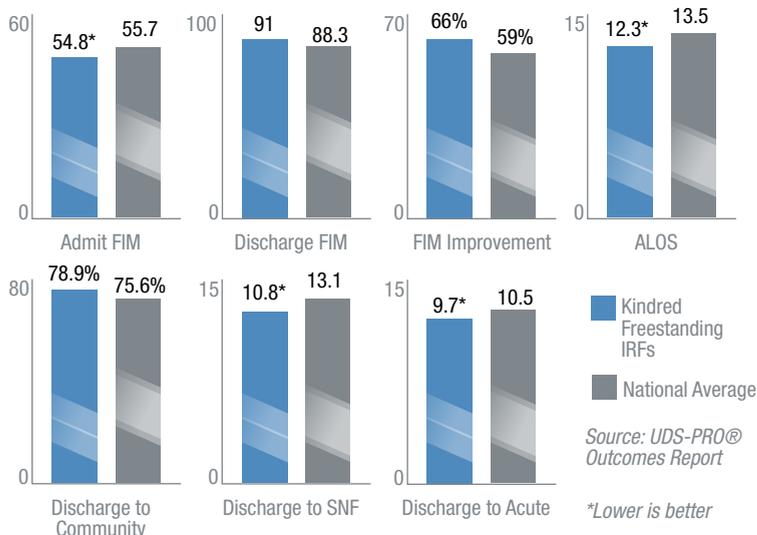
condition-specific programs include: Synapse Neurorehab, a stroke and brain injury rehab program; Steady Rhythms, a cardiopulmonary rehab program; and Steady Steps, a fall management program.

Supporting Partners through Regulatory Compliance

Kindred leaders are skilled in navigating the highly regulated rehabilitation hospital sector and collaborate with CMS and other regulatory agencies to maintain compliance protocols that far exceed regulatory standards. This compliance expertise and ongoing monitoring of regulatory changes relieves the burden on the partner-hospital administration for our managed acute rehabilitation units.

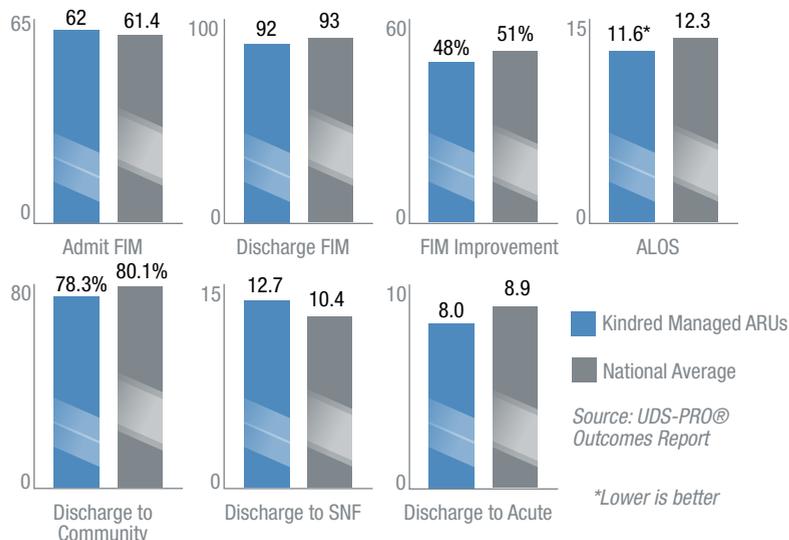
In 2018, Kindred's Freestanding IRFs earned a Program Evaluation Model (PEM) score of **85%**.

Kindred Freestanding IRFs Performance in 2018 Key Quality Measures



In 2018, Kindred's ARUs improved their Program Evaluation Model (PEM) score by **35%**.

Kindred Managed ARUs Performance in 2018 Key Quality Measures



IRFs Driving Unique Value to Unique Patients

For select patient populations, studies have demonstrated that the more intensive rehabilitation provided in IRFs leads to better outcomes than in other settings. Specifically, research has demonstrated that IRFs treat patients with more severe medical and functional profiles on admission than SNFs. Studies demonstrate that IRF hip fracture and joint replacement patients had the most comorbid conditions compared to SNFs and Home Health Agencies (HHAs).

The specialized care furnished in IRFs enables and accelerates superior quality outcomes. Stroke patients have significantly better outcomes when treated at an IRF rather than a SNF. IRF patients had an 8% lower mortality rate and 5% fewer ER visits, and an average length of stay of less than half as long as SNF patients. Patients with a stroke whose post-acute care trajectory included an IRF stay achieved greater functional gains in mobility, daily activity and applied cognition than those who received treatment in a SNF. IRF joint replacement patients achieved larger motor FIM gains and achieved them in a shorter time than patients in SNFs. IRFs have an average hospital readmission rate of 13.4% compared to 22.4% for short-term SNF patients.

In 2017, IRF patients were 90% more likely than SNF patients to be discharged to the community.

Analysis of MedPAC presentation of 2017 CMS data



Helping Customers Navigate a New Payment System

In October 2019, CMS will implement the Patient Driven Payment Model (PDPM) for Skilled Nursing Facilities, which will move away from therapy as a driver for payment. Under the new payment system the focus will move away from the amount of therapy delivered in favor of patient outcomes. Quality of care will be measured in a facility's performance in preventing rehospitalizations, in their ability to discharge patients to the least restrictive setting, and in patient status on discharge. RehabCare's Right Path interdisciplinary clinical pathways model will deliver the expertise for our partner nursing facilities to achieve high-quality patient outcomes as well as improve operational performance.

RehabCare therapists' experience and expertise treating and coding within the LTAC and rehabilitation hospitals payment models will prove invaluable to partner facilities under the new PDPM.

“RehabCare is always on the cutting edge. Excellent support and resources are provided to our teams at the community and home office levels.”

Sara Hamm, SVP of Successful Aging and Health Services, Lifespace Communities

Therapists Committed to Strong Outcomes Across the Continuum

RehabCare is the nation's premier provider of contract rehabilitation services with thousands of therapists delivering medically necessary rehabilitation care and services across a full range of affiliated and unaffiliated healthcare settings to bring about recovery and improved function while supporting the highest quality of life possible.

RehabCare provides contract therapy services across post-acute and senior living settings. The rehabilitation teams use an interdisciplinary approach to drive patient-centered care and track progress through an extensive outcomes-based system. RehabCare serves as a trusted contract rehabilitation partner in 1,586 settings nationwide.

Right Path Clinical Pathways

RehabCare offers a comprehensive suite of clinical excellence programs that are unique to the needs of each partner community and designed to improve patient outcomes, improve transitions



home, and reduce rehospitalizations through an interdisciplinary care approach that extends far beyond the rehab gym. RehabCare’s Right Path Clinical Pathways include targeted programs for fall management, cognitive care, cardiopulmonary rehab, medication management, stroke and brain injury rehab, urinary incontinence, orthopedic rehab and successful transitions home.

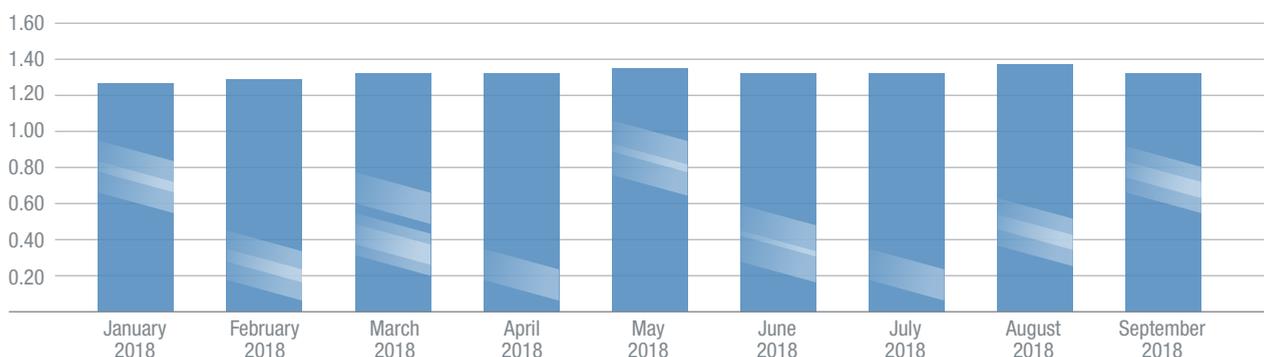
Additionally, we offer clinical excellence programs that meet the unique needs of our assisted living and independent living partners that are designed to maximize health and independence.



“The RehabCare group we have in our building are truly members of our team and take our mission and goals to heart.” *Jane Sheeran, Administrator, Fairview Care Center*



RehabCare’s Functional Outcome Measure Change Evaluation to Discharge



Source: Kindred Internal RehabCare Division Data, Using Modified “Functional Outcomes Measures” (FOMs)

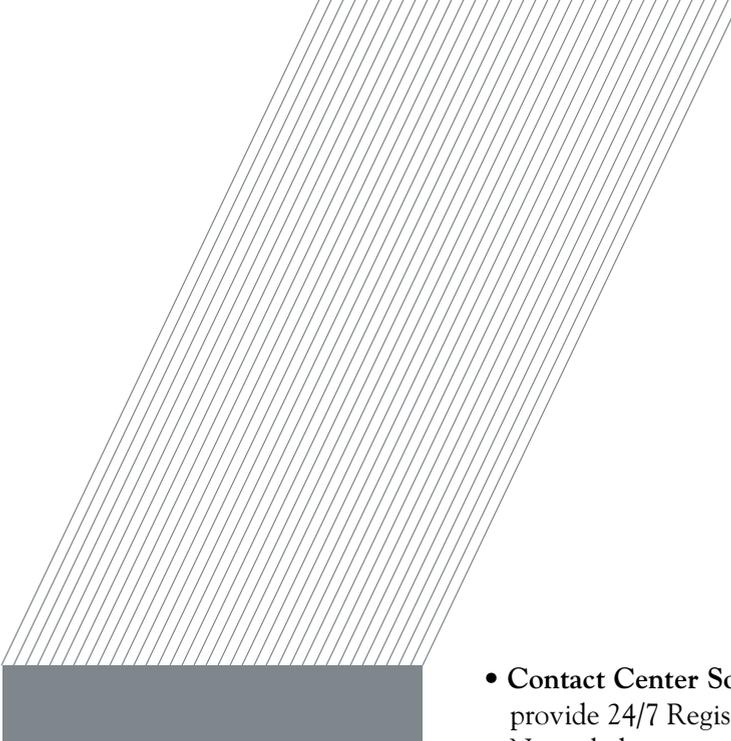
*2017 FOMs not comparable to prior year performance. Historic 7-point FOM scale changed to a 6-point scale in 2017 to match the CMS outcome measurement scale on MDS.



LACUNA

HEALTH

In 2018, Lacuna Health helped support and assist approximately 230,000 patients and their families and our nurse-led teams helped identify more than 45,000 clinical needs post-discharge.



Improving Care Transitions and Supporting Integrated Care

Significant work is already underway to reduce Medicare per-patient costs as it also seeks to improve patient care, including the patient experience, clinical outcomes and reduced rehospitalizations. At Kindred Healthcare, we saw that patients needed continued support after they were discharged from our services in order to fully recover and prevent a decline in their health status. Recognizing this need, we developed Lacuna Health, a subsidiary, to provide ongoing care management and patient engagement services for Kindred patients, as well as unaffiliated partners.

Lacuna Health currently partners with organizations including hospitals, university health systems, physicians, post-acute care providers and ACOs with its Registered Nurse-led programs.

The nurse-led clinical model is designed to address key areas of quality by creating safe patient transitions, improving patient engagement and reducing hospital readmissions. Lacuna Health's three product categories include:



Lacuna Health's mission is to fill gaps in patient engagement and care management along the care continuum to deliver on the promise of an integrated and positive patient experience.



- **Contact Center Solutions** provide 24/7 Registered Nurse-led support and resources to identify the best clinical solutions to meet the specific needs of patients and their families, to help navigate a confusing health system and to answer tough insurance and coverage questions as part of broader consumer-focused engagement efforts.
- **Transitions of Care Services** provide Registered Nurse-led telephone-based patient engagement to identify and manage clinical gaps and medication management as patients transition from a hospital and/or post-acute setting or service.
- **Physician Practice Support** offers clinical resources to support physicians with on-call and after hours services as well as CMS-sponsored care management programs including chronic care management, transitional care management and remote patient monitoring.

Lacuna Health's nurse-led engagement creates positive and personal experiences for patients and caregivers and enables more coordinated care across the continuum. Lacuna Health powers clients to fulfill their promise of patient-centered healthcare through improved patient engagement, better clinical outcomes and lower costs.



Kindred Gives

Giving to Build a Healthy Community

Caring for patients drives everything we do. But our patients are more than their condition. They're fathers, teachers, daughters, cashiers, librarians and all the other things that make a community. Their health, and the health of the community, needs to be cared for. That's why we foster a culture of giving back. Through our dedicated team, we've volunteered thousands of hours for community service, and with their generosity of spirit, given monetary support to health, cultural and educational institutions around the country.

We know that recovery requires a team that comes together to provide care. Building a community also requires coming together. At Kindred, together we give.

A Foundation for Partnership

The Kindred Foundation maximizes resources so our locations are able to support non-profit organizations in their communities, while we nationally develop strong partnerships with two key healthcare-related organizations whose missions are closely aligned with our business – the American Lung Association and the American Heart Association.

We hope to help raise awareness about these important organizations and aid in funding research through our commitment to dollar-for-dollar matching funds for Kindred locations that participate and raise funds for events sponsored by these organizations and many others.

American Lung Association

We've been at the forefront of respiratory care for over three decades. The mission of the American Lung Association is incredibly important to us. Through our involvement in their Fight for Air Climb, Fight for Air Ride, and Trek events we help bring together thousands of people to share in the importance of lung health. Through participation in Lung Force Walks we are raising awareness and funds to help those impacted by lung cancer and other lung diseases, including asthma and COPD.

American Heart Association

Cardiovascular conditions and strokes are prevalent with the patients we serve. Through our partnership with the American Heart Association and participation in events like the Heart Walk we hope to help them in their goal to reduce death and disability from cardiovascular diseases and stroke by 20 percent by 2020.

A Dedication to Education

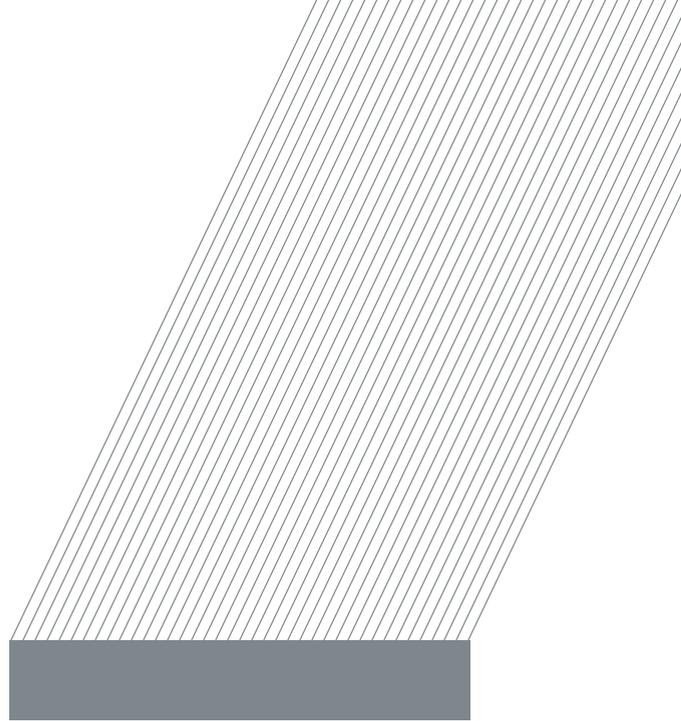
We value the important work our well-trained teammates do each day to care for those in need. To assure the clinical competencies and adoption of best practices by our teams in the field, we are proud to invest in their training, continuing medical education and leadership skills so they may always provide the highest-quality care to our patients. We also believe in maximizing the potential of our employees and offer opportunities to grow by promoting from within.



Showing Compassion for Each Other

Kindred's business is taking care of our patients and families, but sometimes employees themselves need assistance. The HOPE Fund was founded in 1999 to provide monetary assistance to Kindred employees who experience financial hardship due to a catastrophic life event or natural disaster.

Over time, the fund has grown considerably through the generous donations of Kindred employees. In fact, since 2005, the fund has been able to contribute more than \$9.5 million to more than 5,000 team members struggling with loss due to fire or natural disaster, the death of an employee or immediate family member, medical events, domestic violence and other situations that result in severe financial challenges.



Nearly
\$1.5 million
to non-profit
organizations aligned
with our mission

\$3 million
in tuition
reimbursement



We've invested nearly
\$7 million
in employee training

In 2018 The HOPE Fund gave
over **\$1 million**
in hurricane relief



680 South Fourth Street
Louisville, Kentucky 40202
www.kindred.com
1.866.KINDRED



Dedicated to Hope, Healing and Recovery

We accept patients for care regardless of age, race, color, national origin, religion, sex, disability, being a qualified disabled veteran, being a qualified disabled veteran of the Vietnam era, or any other category protected by law, or decisions regarding advance directives.

Exhibit 14

Bed Need Model

Snohomish County Planning Area Rehabilitation Bed Need Methodology, CHARS 2017, OFM Population Estimates
Includes All WA State Rehab Provider Utilization
Step 1

TOTAL NUMBER OF RESIDENT PATIENT DAYS
Only includes WA State Rehab Provider Utilization

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Annual Growth Rate
HSA1	45,157	43,001	40,589	45,305	47,501	47,796	47,017	43,116	44,953	42,012	-0.80%
Snohomish County	6,517	5,653	5,665	7,249	6,781	8,144	6,800	6,707	7,292	5,967	-0.98%
STATEWIDE TOTAL	85,968	84,263	82,189	88,016	89,702	87,946	83,982	76,814	81,765	75,546	-1.44%

Source: CHARS 2008-2017

*Note: Does not include out-migration to other states

Snohomish County Planning Area Rehabilitation Bed Need Methodology, CHARS 2017, OFM Population Estimates
Includes All WA State Rehab Provider Utilization
Step 2

2007-2016 TOTAL NUMBER OF PATIENT DAYS

Only includes WA State Rehab Provider Utilization

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
HSA1	45,157	43,001	40,589	45,305	47,501	47,796	47,017	43,116	44,953	42,012
Snohomish County	6,517	5,653	5,665	7,249	6,781	8,144	6,800	6,707	7,292	5,967
STATEWIDE TOTAL	85,968	84,263	82,189	88,016	89,702	87,946	83,982	76,814	81,765	75,546

2007-2016 TOTAL NUMBER OF PSYCHIATRIC PATIENT DAYS

In Psychiatric Hospitals.

Psychiatric hospitals: BHC Fairfax, BHC Fairfax North, BHC Fairfax Monroe, Cascade Behavioral Health, West Seattle Psychiatric and Puget Sound Behavioral Health in HSA1, and Lourdes Counseling Center in HSA3.

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
HSA1	0	0	0	0	0	0	0	0	0	0
Snohomish County	0	0	0	0	0	0	0	0	0	0
STATEWIDE TOTAL	0	0	0	0	0	0	0	0	0	0

2007-2016 TOTAL NUMBER OF PATIENT DAYS MINUS PSYCH DAYS

Only includes WA State Rehab Provider Utilization

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
HSA1	45,157	43,001	40,589	45,305	47,501	47,796	47,017	43,116	44,953	42,012
Snohomish County	6,517	5,653	5,665	7,249	6,781	8,144	6,800	6,707	7,292	5,967
STATEWIDE TOTAL	85,968	84,263	82,189	88,016	89,702	87,946	83,982	76,814	81,765	75,546

Source: CHARS 2008-2017

*Note: Does not include out-migration to other states

Snohomish County Planning Area Rehabilitation Bed Need Methodology, CHARS 2017, OFM Population Estimates
Includes All WA State Rehab Provider Utilization
Step 3

TOTAL NUMBER OF PATIENT DAYS MINUS PSYCH DAYS

Only includes WA State Rehab Provider Utilization

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Annual Growth Rate
HSA1	45,157	43,001	40,589	45,305	47,501	47,796	47,017	43,116	44,953	42,012	-0.80%
Snohomish County	6,517	5,653	5,665	7,249	6,781	8,144	6,800	6,707	7,292	5,967	-0.98%
STATEWIDE TOTAL	85,968	84,263	82,189	88,016	89,702	87,946	83,982	76,814	81,765	75,546	-1.44%

TOTAL POPULATIONS

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Annual Growth Rate
HSA1	3,361,479	3,392,416	3,420,099	3,447,263	3,475,469	3,513,595	3,564,713	3,623,407	3,702,414	3,774,633	1.29%
Snohomish County	556,725	563,180	570,188	574,946	581,428	588,963	598,469	613,046	625,749	639,205	1.54%
STATEWIDE TOTAL	5,301,164	5,363,736	5,416,773	5,461,155	5,509,690	5,569,241	5,645,686	5,727,404	5,830,041	5,933,394	1.25%

USE RATE PER 1,000

Only includes WA State Rehab Provider Utilization

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Annual Growth Rate
HSA1	13.4	12.7	11.9	13.1	13.7	13.6	13.2	11.9	12.1	11.1	-2.09%
Snohomish County	11.7	10.0	9.9	12.6	11.7	13.8	11.4	10.9	11.7	9.3	-2.51%
STATEWIDE TOTAL	16.2	15.7	15.2	16.1	16.3	15.8	14.9	13.4	14.0	12.7	-2.69%

Source: CHARS 2008-2017; OFM SADE 2008-2017; OFM Forecast of the State Population by Age and Sex (2017 Release)

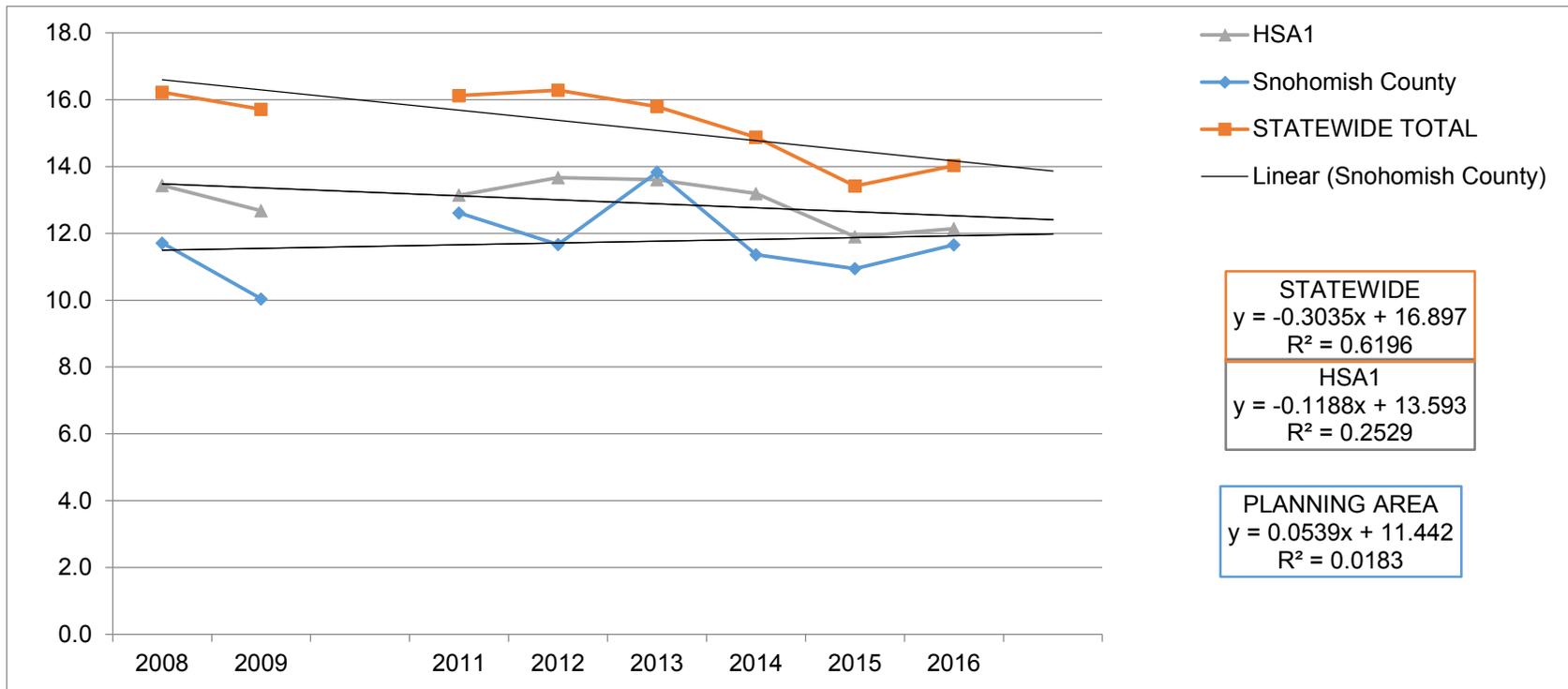
*Note: Does not include out-migration to other states

Snohomish County Planning Area Rehabilitation Bed Need Methodology, CHARS 2017, OFM Population Estimates
Includes All WA State Rehab Provider Utilization
Step 4

USE RATE PER 1,000 [Excluding Outlier Years 2010 and 2017]

Only includes WA State Rehab Provider Utilization

	2008	2009		2011	2012	2013	2014	2015	2016		Slope
HSA1	13.4	12.7		13.1	13.7	13.6	13.2	11.9	12.1		-0.119
Snohomish County	11.7	10.0		12.6	11.7	13.8	11.4	10.9	11.7		0.054
STATEWIDE TOTAL	16.2	15.7		16.1	16.3	15.8	14.9	13.4	14.0		-0.303



*Note: Does not include out-migration to other states

Snohomish County Planning Area Rehabilitation Bed Need Methodology, CHARS 2017, OFM Population Estimates
Includes All WA State Rehab Provider Utilization
Step 5

STEP #5
2017 DATA

	Total Patient Days	Out of State Residents	WA Residents	Out of State as % of WA Residents
To Snohomish County Hospitals				
15-64	2,313	40	2,273	1.76%
65+	2,549	37	2,512	1.47%
TOTAL	4,862	77	4,785	1.61%
To WA - Planning Area Hospitals				
15-64	33,295	2,858	30,437	9.39%
65+	43,138	2,813	40,325	6.98%
TOTAL	76,433	5,671	70,762	8.01%
Total patient days to WA Hospitals	81,294	5,748	75,546	7.61%

	TO Snohomish County Hospitals	TO WA - Planning Area Hospitals	Days in Oregon hospitals	Total Days for Residents
Washington Residents FROM Snohomish County				
15-64	1,961	1,102	0	3,063
65+	2,078	827	0	2,904
TOTAL	4,039	1,929	0	5,967
FROM WA - Planning Area				
15-64	312	29,335	624	30,271
65+	434	39,498	302	40,234
TOTAL	746	68,833	926	70,505
Totals:	4,785	70,762	926	76,472

WA Source: CHARS 2017 Only includes WA State Rehab Provider Utilization
 Oregon Source: Oregon Hospital Discharge Data 2015, DRGs 945 and 946 (Rehab)

MARKET SHARE
PERCENTAGE OF PATIENT DAYS

	TO Snohomish County	TO WA - Planning Area	To Oregon Hospitals
% OF Snohomish County Residents			
15-64	64.02%	35.98%	0.00%
65+	71.54%	28.46%	0.00%
TOTAL	67.68%	32.32%	0.00%
% OF WA - Planning Area Residents			
15-64	1.03%	96.91%	2.06%
65+	1.08%	98.17%	0.75%
TOTAL	1.06%	97.63%	1.31%

POPULATIONS BY Snohomish County

	Snohomish County	WA - Planning Area	Total Pop WA
15-64	530,983	4,280,632	4,811,615
65+	108,222	1,013,557	1,121,779
TOTAL	639,205	5,294,189	5,933,394

NOTE: 50% of Planning Area resident days at Swedish Cherry Hill's rehabilitation unit are included in 'Planning Area Hospital' days

Snohomish County Planning Area Rehabilitation Bed Need Methodology, CHARS 2017, OFM Population Estimates
Includes All WA State Rehab Provider Utilization
Step 6

2017 Data

USE RATE BY PLANNING AREA (defined as age specific inpatient days per 1,000 population)

	Snohomish County	WA - Planning Area
USE RATES		
15-64	5.77	7.07
65+	26.83	39.70

Snohomish County Planning Area Rehabilitation Bed Need Methodology, CHARS 2017, OFM Population Estimates
Includes All WA State Rehab Provider Utilization
Step 7

USE RATE BY Snohomish County Planning Area FROM STEP 6

	2017
BASE YEAR USE RATES	
15-64	5.77
65+	26.83

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
Snohomish County Planning Area															
PROJECTED USE RATES*															
15-64 using Planning Area Trend	5.82	5.88	5.93	5.98	6.04	6.09	6.15	6.20	6.25	6.31	6.36	6.42	6.47	6.52	6.58
15-64 using Statewide Trend	5.47	5.16	4.86	4.55	4.25	3.95	3.64	3.34	3.04	2.73	2.43	2.13	1.82	1.52	1.40
65+ using Planning Area Trend	26.89	26.94	27.00	27.05	27.10	27.16	27.21	27.26	27.32	27.37	27.43	27.48	27.53	27.59	27.64
65+ using Statewide Trend	26.53	26.23	25.92	25.62	25.32	25.01	24.71	24.41	24.10	23.80	23.50	23.19	22.89	22.58	22.47

*State Health Plan specifies projected by applying either the HSA trend or Statewide trend, whichever trend would result in the smaller adjustment. **NOTE: this model assumes use of Planning Area Trend**
Bold Print indicates use rate closest to current value

Snohomish County Planning Area Rehabilitation Bed Need Methodology, CHARS 2017, OFM Population Estimates
Includes All WA State Rehab Provider Utilization
Step 8

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
Snohomish County Planning Area																
<i>(using Trend slope from Step 4 for future year adjustments)</i>																
USE RATES																
15-64	5.77	5.82	5.88	5.93	5.98	6.04	6.09	6.15	6.20	6.25	6.31	6.36	6.42	6.47	6.52	6.58
65+	26.83	26.89	26.94	27.00	27.05	27.10	27.16	27.21	27.26	27.32	27.37	27.43	27.48	27.53	27.59	27.64
PROJECTED POPULATION																
15-64	530,983	538,342	545,804	554,377	557,850	561,344	564,860	568,399	572,015	575,382	578,768	582,174	585,601	589,098	593,684	598,306
65+	108,222	114,021	120,131	125,219	131,203	137,472	144,041	150,924	159,013	164,953	171,115	177,507	184,138	191,668	196,410	201,270
TOTALS	639,205	652,364	665,935	679,596	689,052	698,816	708,901	719,322	731,028	740,335	749,883	759,681	769,739	780,766	790,094	799,576
PROJECTED # OF PATIENT DAYS for Snohomish County Planning Area Residents																
15-64	3,063	3,134	3,207	3,288	3,338	3,389	3,441	3,493	3,546	3,598	3,651	3,704	3,757	3,811	3,873	3,935
65+	2,904	3,066	3,237	3,380	3,549	3,726	3,912	4,107	4,335	4,506	4,684	4,868	5,060	5,277	5,419	5,564
TOTALS	5,967	6,200	6,444	6,668	6,887	7,115	7,353	7,600	7,882	8,105	8,335	8,572	8,817	9,089	9,291	9,499

Source: OFM Population Estimates and Projection (2017 Release)

Snohomish County Planning Area Rehabilitation Bed Need Methodology, CHARS 2017, OFM Population Estimates
Includes All WA State Rehab Provider Utilization
Step 9

9C Planning Area Resident Patient Days to Planning Area Providers	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
<i>Planning Area Residents To Planning Area Providers</i>																
15-64	1,961	2,007	2,053	2,105	2,137	2,170	2,203	2,237	2,270	2,304	2,337	2,371	2,405	2,440	2,479	2,519
65+	2,078	2,193	2,315	2,418	2,539	2,666	2,798	2,938	3,102	3,224	3,351	3,483	3,620	3,775	3,876	3,980
TOTALS	4,039	4,200	4,369	4,523	4,676	4,836	5,002	5,174	5,372	5,528	5,688	5,854	6,025	6,215	6,356	6,500
<i>Planning Area Residents To Other WA Providers</i>																
15-64	1,102	1,128	1,154	1,183	1,201	1,219	1,238	1,257	1,276	1,295	1,313	1,332	1,352	1,371	1,393	1,416
65+	827	873	921	962	1,010	1,060	1,113	1,169	1,234	1,283	1,333	1,386	1,440	1,502	1,542	1,583
TOTALS	1,929	2,000	2,075	2,145	2,211	2,280	2,351	2,426	2,510	2,577	2,647	2,718	2,792	2,873	2,936	2,999
<i>Planning Area Residents To Oregon Providers</i>																
15-64	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65+	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTALS	0															
9D Other WA Resident Patient Days to Planning Area Providers																
<i>Other WA Residents To Planning Area Providers</i>																
15-64	312	309	306	302	299	295	291	287	283	279	275	271	267	263	259	256
65+	434	452	470	490	508	526	543	559	575	591	605	619	631	642	650	657
TOTALS	746	762	777	792	807	821	834	846	858	870	880	890	898	905	910	913
<i>Other WA Residents To Other WA Providers</i>																
15-64	29,335	29,079	28,786	28,438	28,103	27,758	27,394	27,020	26,619	26,223	25,848	25,470	25,100	24,739	24,398	24,057
65+	39,498	41,169	42,810	44,566	46,220	47,829	49,419	50,873	52,331	53,788	55,099	56,357	57,459	58,406	59,158	59,806
TOTALS	68,833	70,247	71,596	73,004	74,323	75,586	76,813	77,893	78,950	80,011	80,947	81,827	82,558	83,144	83,556	83,863
<i>Other WA Residents To Oregon Providers</i>																
15-64	624	619	612	605	598	590	583	575	566	558	550	542	534	526	519	512
65+	302	315	327	341	353	366	378	389	400	411	421	431	439	447	452	457
TOTALS	926	933	940	946	951	956	961	964	966	969	971	973	973	973	971	969

Snohomish County Planning Area Rehabilitation Bed Need Methodology, CHARS 2017, OFM Population Estimates
Includes All WA State Rehab Provider Utilization
Step 9

9E Total WA Resident Patient Days to Planning Area Providers																	
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	
<i>Total Wa Resident Days to Planning Area Providers</i>																	
15-64	2,273	2,316	2,360	2,407	2,436	2,465	2,494	2,524	2,554	2,583	2,612	2,642	2,672	2,703	2,739	2,775	
65+	2,512	2,646	2,786	2,908	3,047	3,191	3,341	3,497	3,677	3,815	3,956	4,102	4,251	4,417	4,526	4,637	
TOTALS	4,785	4,962	5,145	5,315	5,483	5,656	5,836	6,021	6,230	6,397	6,568	6,744	6,924	7,120	7,265	7,413	
<i>Total Wa Resident Days to Other WA Providers</i>																	
15-64	30,437	30,206	29,940	29,621	29,304	28,977	28,632	28,277	27,895	27,518	27,161	26,802	26,451	26,110	25,791	25,473	
65+	40,325	42,041	43,732	45,528	47,230	48,889	50,532	52,041	53,565	55,071	56,432	57,743	58,899	59,908	60,700	61,389	
TOTALS	70,762	72,247	73,671	75,149	76,534	77,866	79,164	80,318	81,460	82,589	83,593	84,545	85,350	86,017	86,491	86,862	
<i>Total Wa Resident Days to OR Providers</i>																	
15-64	624	619	612	605	598	590	583	575	566	558	550	542	534	526	519	512	
65+	302	315	327	341	353	366	378	389	400	411	421	431	439	447	452	457	
TOTALS	926	933	940	946	951	956	961	964	966	969	971	973	973	973	971	969	
9F Total Patient Days Including out of State Residents																	
% Out of State Resident Patient Days, 2016 (From Step 5A)																	
<i>Planning Area</i>																	
15-64	1.76%																
65+	1.47%																
TOTALS	1.61%																
<i>Other Washington</i>																	
15-64	9.39%																
65+	6.98%																
TOTALS	8.01%																
Planning Area Provider Total Patient Days, Including Out of State Residents																	
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	
15-64	2,313	2,357	2,401	2,450	2,479	2,509	2,538	2,568	2,599	2,628	2,658	2,688	2,719	2,751	2,787	2,824	
65+	2,549	2,685	2,827	2,951	3,092	3,238	3,391	3,548	3,731	3,871	4,015	4,163	4,314	4,482	4,593	4,706	
TOTALS	4,862	5,041	5,228	5,400	5,571	5,747	5,929	6,117	6,329	6,499	6,673	6,851	7,033	7,233	7,380	7,530	

Snohomish County Planning Area Rehabilitation Bed Need Methodology, CHARS 2017, OFM Population Estimates
Includes All WA State Rehab Provider Utilization
Step 10

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	Average Annual Growth
Snohomish County Planning Area								7-Years								15 years	
Population 15-64 (1)	530,983	538,342	545,804	554,377	557,850	561,344	564,860	568,399	572,015	575,382	578,768	582,174	585,601	589,098	593,684	598,306	0.8%
15-64 Use Rate (2)	5.77	5.82	5.88	5.93	5.98	6.04	6.09	6.15	6.20	6.25	6.31	6.36	6.42	6.47	6.52	6.58	0.9%
Population 65+ (1)	108,222	114,021	120,131	125,219	131,203	137,472	144,041	150,924	159,013	164,953	171,115	177,507	184,138	191,668	196,410	201,270	4.1%
65+ Use Rate (2)	26.83	26.89	26.94	27.00	27.05	27.10	27.16	27.21	27.26	27.32	27.37	27.43	27.48	27.53	27.59	27.64	0.2%
Total Population	639,205	652,364	665,935	679,596	689,052	698,816	708,901	719,322	731,028	740,335	749,883	759,681	769,739	780,766	790,094	799,576	1.5%
Total Snohomish County Planning Area Resident Days	5,967	6,200	6,444	6,668	6,887	7,115	7,353	7,600	7,882	8,105	8,335	8,572	8,817	9,089	9,291	9,499	3.1%
Total Days in Snohomish County Planning Area Hospitals	4,862	5,041	5,228	5,400	5,571	5,747	5,929	6,117	6,329	6,499	6,673	6,851	7,033	7,233	7,380	7,530	2.9%
Available Beds (3)																	
<i>Providence Regional Medical Center Everett</i>	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	
TOTAL	19	19	19	19	19	19	19	19	19	19							
Wtd Occ Std	55.00%	55.00%	55.00%	55.00%	55.00%	55.00%	55.00%	55.00%	55.00%	55.00%	55.00%	55.00%	55.00%	55.00%	55.00%	55.00%	
Gross Bed Need (TPD/365/Occupancy)--Demand	24.2	25.1	26.0	26.9	27.7	28.6	29.5	30.5	31.5	32.4	33.2	34.1	35.0	36.0	36.8	37.5	2.9%
Bed Supply	19.0	19.0	19.0	19.0	19.0	19.0	19.0	19.0	19.0	19.0	19.0	19.0	19.0	19.0	19.0	19.0	
Net Bed Need/Surplus (Demand - Supply)	5.2	6.1	7.0	7.9	8.7	9.6	10.5	11.5	12.5	13.4	14.2	15.1	16.0	17.0	17.8	18.5	

(1) Population Sources: OFM SADE 2008-2017; OFM Medium Series Projections (2017 Release); OFM Forecast of the State Population by Age and Sex (2017 Release)

(2) 2017 Resident (Age 15 and older) Use Rate Data Source: CHARS 2017 and 2015 Oregon Hospital Discharge Data. See Steps 5 & 6. Future

(3) Bed supply sources: Certificate of Need #1602 issued to Providence Regional Medical Center Everett

(4) Weighted Occupancy: Calculated per 1987 Washington State Health Plan as the sum, across all hospitals in the planning area, of each hospital's occupancy rate times that hospital's percentage of total beds in the area.

Alterations to original methodology:

#1. 50% of Planning Area (Snohomish County) resident patient days at Swedish Cherry Hill are included within 'Planning Area Hospital' utilization in Step 5.

#2. [Excluding outlier years CY2010 and CY2017] The Planning Area (Snohomish) resident use-rate trend from Step 4 was applied to use-rate projections in Step 7 rather than the traditional Health Service Area / Statewide trend approach

Exhibit 15

Providence Regional Medical Center Everett Charity Policy

	Original Effective Date: January 2000	Page 1 of 7	Policy Number FIN-300
	Last Revision Date: October 2015 Revision Effective Date: January 2016		
Subject: Washington Charity Care Policy		Authorization: VP Revenue Cycle	

Purpose:

The purpose of this policy is to set forth Providence Health & Services (PH&S)'s Financial Assistance and Emergency Medical Care policies, which are designed to promote access to medically necessary care for those without the ability to pay, and to offer a discount from billed charges for individuals who are able to pay for only a portion of the costs of their care. These programs apply solely with respect to emergency and other medically necessary healthcare services provided by PH&S. This policy and the financial assistance programs described herein constitute the official Financial Assistance Policy ("FAP") and Emergency Medical Care Policy for each hospital that is owned, leased or operated by PH&S within Washington State.

PH&S Hospitals in Washington State:

Providence Centralia Hospital, Providence St. Joseph's Hospital, Providence Mount Carmel Hospital, Providence Regional Medical Center, Providence St. Peter Hospital, Providence Sacred Heart Medical Center & Children's Hospital, Providence Holy Family Hospital, and Providence St. Mary Medical Center.

Policy:

PH&S is a Catholic healthcare organization guided by a commitment to its Mission and Core Values, designed to reveal God's love for all, especially the poor and vulnerable, through compassionate service. It is both the philosophy and practice of each PH&S ministry that medically necessary healthcare services are available to community members and those in emergent medical need, without delay, regardless of their ability to pay. For purposes of this policy, "financial assistance" includes charity care and other financial assistance programs offered by PH&S.

1. PH&S will comply with federal and state laws and regulations relating to emergency medical services, patient financial assistance, and charity care, including but not limited to Section 1867 of the Social Security Act, Section 501(r) of the Internal Revenue Code, RCW 70.170.060, and WAC Ch. 246-453.
2. PH&S will provide financial assistance to qualifying patients or guarantors with no other primary payment sources to relieve them of all or some of their financial obligation for emergency and medically necessary PH&S healthcare services.
3. In alignment with its Core Values, PH&S will provide financial assistance to qualifying patients or guarantors in a respectful, compassionate, fair, consistent, effective and efficient manner.
4. PH&S will not discriminate on the basis of age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other basis prohibited by federal, state, or local law when making financial assistance determinations.
5. In extenuating circumstances, PH&S may at its discretion approve financial assistance outside of the scope of this policy. Uncollectible/presumptive charity is approved due to but not limited to the following: social diagnosis, homelessness, bankruptcy, deceased with no estate, history of

non-compliance and non-payment of account(s). All documentation must support the patient/guarantors inability to pay and why collection agency assignment would not result in resolution of the account.

6. PH&S hospitals with dedicated emergency departments will provide, without discrimination, care for emergency medical conditions (within the meaning of the Emergency Medical Treatment and Labor Act (EMTALA) consistent with available capabilities, regardless of whether an individual is eligible for financial assistance. PH&S hospitals will provide emergency medical screening examinations and stabilizing treatment, or refer or transfer an individual if such transfer is appropriate in accordance with 42 C.F.R. 482.55. PH&S prohibits any actions that would discourage individuals from seeking emergency medical care, such as by permitting debt collection activities that interfere with the provision of emergency medical care.

Providers Subject to PH&S's FAP:

In addition to each applicable PH&S hospital facility, all physicians and other providers rendering care to PH&S patients during a hospital stay are subject to these policies unless specifically identified otherwise. Attachment A indicates where patients may obtain the list(s) pertaining to all Providers who render care in the PH&S hospital departments, and whether or not they are subject to the PH&S Financial Assistance Policy. This list can be accessed online at www.providence.org, and is also available in paper form by request to the Financial Counselor at the Hospital.

Financial Assistance Eligibility Requirements:

Financial assistance is available for both uninsured and underinsured patients and guarantors where such assistance is consistent with federal and state laws governing permissible benefits to patients. Financial assistance is available only with respect to amounts that relate to emergency or other medically necessary services. Patients or guarantors with gross family income, adjusted for family size, at or below 350% of the Federal Poverty Level (FPL) are eligible for financial assistance, so long as no other financial resources are available and the patient or guarantor submits information necessary to confirm eligibility.

Financial assistance is secondary to all other financial resources available to the patient or guarantor, including but not limited to insurance, third party liability payors, government programs, and outside agency programs. In situations where appropriate primary payment sources are not available, patients or guarantors may apply for financial assistance based on the eligibility requirements in this policy and supporting documentation, which may include:

- Proof of application to Medicaid may be requested.

Financial assistance is granted for emergency and medically necessary services only. For PH&S hospitals, "emergency and medically necessary services" means appropriate hospital based services as defined by WAC 246-453-010(7). For other PH&S ministries and physician services these are medically necessary services provided within a PH&S hospital or in such other settings as defined by PH&S.

Patients who reside outside the PH&S service area where services are provided are not eligible for financial assistance, except under the following circumstances:

- The patient requires emergency services while visiting in PH&S's service area.
- Medically necessary care provided to the patient is not available at a PH&S facility in the service area where the patient resides.

The PH&S service area is defined as any Washington counties serviced by the PH&S hospital.

Eligibility for financial assistance shall be based on financial need at the time of application. All income of the family as defined by Washington law governing charity care ¹ is considered in determining the applicability of the PH&S sliding fee scale in Attachment B. Patients seeking financial assistance must provide any supporting documentation specified in the application for financial assistance, unless PH&S indicates otherwise.

Basis for Calculating Amounts Charged to Patients Eligible for Financial Assistance

Categories of available discounts and limitations on charges under this policy include:

- **100 Percent Discount/Free Care:** Any patient or guarantor whose gross family income, adjusted for family size, is at or below 300% of the current federal poverty level (“FPL”) is eligible for a 100 percent discount off of total hospital charges for emergency or medically necessary care, to the extent that the patient or guarantor is not eligible for other private or public health coverage sponsorship.²
- **Discounts Off Charges at 75 Percent :** The PH&S sliding fee scale set forth in Attachment B will be used to determine the amount of financial assistance to be provided in the form of a discount of 75 percent for patients or guarantors with incomes between 301% and 350% of the current federal poverty level after all funding possibilities available to the patient or guarantor have been exhausted or denied and personal financial resources and assets have been reviewed for possible funding to pay for billed charges. Financial assistance may be offered to patients or guarantors with family income in excess of 350% of the federal poverty level when circumstances indicate severe financial hardship or personal loss.
- **Limitation on Charges for all Patients Eligible for Financial Assistance:** No patient or guarantor eligible for any of the above-listed discounts will be personally responsible for more than the “Amounts Generally Billed” (AGB) percentage of gross charges, as defined in Treasury Regulation Section 1.501(r)-1(b)(2), by the applicable PH&S hospital for the emergency or other medically necessary services received. PH&S determines the applicable AGB percentage for each PH&S hospital by multiplying the hospital’s gross charges for any emergency or medically necessary care by a fixed percentage which is based on claims allowed under Medicare. Information sheets detailing the AGB percentages used by each PH&S Hospital, and how they are calculated, can be obtained by visiting the following website: www.providence.org or by calling: **1-866-747-2455** to request a paper copy. In addition, the maximum amount that may be collected in a 12 month period for emergency or medically necessary health care services to patients eligible for financial assistance is 20 percent of the patient’s gross family income, provided that the patient remains eligible for financial assistance under this policy throughout the 12-month period.

Method for Applying for Assistance and Evaluation Process:

Patients or guarantors may apply for financial assistance under this Policy by any of the following means: (1) advising PH&S’s patient financial services staff at or prior to the time of discharge that assistance is requested, and submitting an application form and any documentation if requested by PH&S; (2) downloading an application form from PH&S’ website, at: www.providence.org, and submitting the form together with any required documentation; (3) requesting an application form by telephone, by calling: **1-866-747-2455**, and submitting the form; or (4) any other methods specified in PH&S’s Billing and Collections Policy. PH&S will display signage and information

¹ “Income” and “family” are defined in WAC 246-453-010(17)-(18).

² See RCW 70.170.060 (5).

about its financial assistance policy at appropriate access areas. Including but not limited to the emergency department and admission areas.

The hospital will give a preliminary screening to any person applying for financial assistance. As part of this screening process PH&S will review whether the person has exhausted or is ineligible for any third-party payment sources. PH&S may choose to grant financial assistance based solely on an initial determination of a patient's status as an indigent person, as defined in WAC 246-453-010(4). In these cases, documentation may not be required. In all other cases, documentation is required to support an application for financial assistance. This may include proof of family size and income and assets from any source, including but not limited to: copies of recent paychecks, W-2 statements, income tax returns, forms approving or denying Medicaid or state-funded medical assistance, forms approving or denying unemployment compensation, written statements from employers or welfare agencies, and/or bank statements showing activity. If adequate documentation cannot be provided, PH&S may ask for additional information.

A patient or guarantor who may be eligible to apply for financial assistance may provide sufficient documentation to PH&S to support an eligibility determination until fourteen (14) days after the application is made or two hundred forty (240) days after the date the first post-discharge bill was sent to the patient, whichever is later per the 501(r) regulations. PH&S acknowledges that per the WAC 246-453-020(10), a designation can be made at any time upon learning that a party's income is below 200% of the federal poverty standard. Based upon documentation provided with the application, PH&S will determine if additional information is required, or whether an eligibility determination can be made. The failure of a patient or guarantor to reasonably complete appropriate application procedures within the time periods specified above shall be sufficient grounds for PH&S to determine the patient or guarantor ineligible for financial assistance and to initiate collection efforts. An initial determination of potential eligibility for financial assistance will be completed as closely as possible to the date of the application.

PH&S will notify the patient or guarantor of a final determination of eligibility or ineligibility within ten (10) business days of receiving the necessary documentation.

The patient may appeal a determination of ineligibility for financial assistance by providing relevant additional documentation to PH&S within thirty (30) days of receipt of the notice of denial. All appeals will be reviewed and if the determination on appeal affirms the denial, written notification will be sent to the patient and the Washington State Department of Health in accordance with state law. The final appeal process will conclude within ten (10) days of the receipt of the appeal by PH&S.

Other methods of qualifications for Financial Assistance may fall under the following:

- The legal statute of collection limitations has expired;
- The guarantor has deceased and there is no estate or probate;
- The guarantor has filed bankruptcy;
- The guarantor has provided financial records that qualify him/her for financial assistance; and/or
- Financial records indicate the guarantor's income will never improve to be able to pay the debt, for example with guarantors on lifetime fixed incomes.

Billing and Collections: Any unpaid balances owed by patients or guarantors after application of available discounts, if any, referred to collections in accordance with PH&S's uniform billing and collections policies. For information on PH&S' billing and collections practices for amounts owed by patients or guarantors, please see PH&S's Billing and Collections Policy, which is available free of charge at each PH&S hospital's registration desk, at: www.providence.org; or which can be sent to you if you call: **1-866-747-2455**.

AUTHORIZATION:

Teresa Spalding
VP Revenue Cycle

Signature on file

Date:

ATTACHMENT A
**Hospital-Based Providers Not Subject to PH&S's Financial Assistance Policy and
Associated Discounts**

A list is available of all Providers who render care in the PH&S Hospital, and whether or not they are subject to the PH&S Financial Assistance Policy. This list can be accessed online at www.providence.org, and is also available in paper form by request to the Financial Counselor at the Hospital. If a Provider is not subject to the Financial Assistance Policy then that Provider will bill patients separately for any professional services that that provider provides during a patient's hospital stay, based on the Provider's own applicable financial assistance guidelines, if any.

ATTACHMENT B
Discounts Available Under PH&S's Financial Assistance/Charity Care Policy

The full amount of hospital charges outstanding after application of any other available sources of payment will be determined to be charity care for any patient or guarantor whose gross family income, adjusted for family size, is at or below 300% of the current federal poverty guideline level (consistent with WAC Ch. 246-453), provided that such persons are not eligible for other private or public health coverage sponsorship (see RCW 70.170.060 (5)).

For guarantors with income and resources above 101% of the FPL the PH&S sliding fee scale below applies.

In determining the applicability of the PH&S fee scale, all income of the family as defined by WAC 246-456-010 (17-18) are taken into account. Responsible parties with family income and assets between 100% and 300% of the FPL, adjusted for family size, shall be determined to be indigent persons qualifying for charity sponsorship for the full amount of hospital charges related to appropriate hospital-based medical services that are not covered by private or public third-party sponsorship as referenced in WAC 246-453-040 (1-3).

For guarantors with income and assets above 300% of the FPL household income and assets are considered in determining the applicability of the sliding fee scale.

Assets considered for evaluation; IRAs, 403(b) accounts, and 401(k) accounts are exempt under this policy, unless the patient or guarantor is actively drawing from them. For all other assets, the first \$100,000 is exempt.

Income and assets as a percentage of Federal Poverty Guideline Level	Percent of discount (write-off) from original charges	Balance billed to guarantor
100-300%	100%	0%
301-350%	75%	25%

Exhibit 16

Providence Regional Medical Center Everett Admissions Policy



Implementation:	10/2000
Effective:	09/2017
Last Reviewed:	09/2017
Last Revised:	09/2017
Next Review:	09/2020
Owner:	<i>Theresa Amihere Bervell</i>
Policy Area:	<i>Compliance</i>
References:	<i>Nondiscrimination Policy, PROV-ICP-729</i>
Applicability:	<i>WA - Providence Regional MC Everett WA - NWR Providence Medical Group</i>

Patient Rights and Responsibilities Procedure

Scope

This procedure provides the local ministry with additional specifics in support of the system-led policy entitled [Patient Rights and Responsibilities](#).

These procedures apply to all caregivers of the Providence Northwest Washington Region including: caregivers, medical staff members, contracted service providers, and volunteers. It also applies to all vendors, representatives, and any other individuals providing services to or on behalf of Providence Northwest Washington Region. All of these groups will be referenced in this policy as "caregivers and representatives."

Purpose

Process for assuring that patients are informed of their rights and responsibilities.

Definitions

- Admitting representative: anyone who registers or activates an account upon the patient's arrival to NWR.
- Bedded patients: Includes in-patients, ambulatory surgery and observation patients.
- Outpatient Service: Includes series encounters such as Imaging, Breast Center, Children's Center, Radiation Oncology etc.
- Patient Handbook: Brochure 39493 "Helpful Information for Patients and Families" which includes a description of Patients Rights and Responsibilities, as well as information on how to make a complaint or file a grievance.

Procedure

In keeping with its Mission and Vision, Providence Northwest Washington Region provides care, treatment, and services in a way that respects and fosters patient's dignity, autonomy, positive self-regard, civil rights, and involvement in their care. It is the policy of Providence to honor the diverse cultures, beliefs, and practices of our patients. Patient rights brochures and posters will be consistent with federal, state, WA Department of Health, The Joint Commission and Center for Medicare and Medicaid (CMS) standards related to patient rights. The document [Comparison of Patient Rights Policy to Requirements](#) is a summary of how NWR complies with WAC 246-320-141, CMS Guidelines and The Joint Commission standards related to patient

rights.

Process

What Happens	Who's Responsible
<p>Informing patients of their rights.</p> <ol style="list-style-type: none">1. Patient Rights signs are posted in all primary facility entrances, as well as entrances to offsite NWR services within clinics and pharmacies.2. Every NWR patient will receive a patient handbook the first time s/he registers as a NWR patient.3. For Outpatient Service including series encounters, patients will receive a patient handbook for all initial visits and at least annually thereafter.4. The patient handbook will be available to any patient upon request during subsequent visits.	<ul style="list-style-type: none">• Admitting and Check In area representatives including clinical units direct admits give this patient handbook at the time of registration or check in and document in EPIC on the document screen by typing the date that handbook is given to the patient under "date received".
<p>Educating staff and providers about patient rights.</p> <p>All Caregivers and providers are educated regarding their unique role in supporting patient's rights and responsibilities.</p>	<ul style="list-style-type: none">• Human Resources representatives distribute the Code of Conduct during the New Caregiver orientation process.• New Employee Orientation agenda includes Integrity, Compliance, and Confidentiality presentations.• Department Managers provide ongoing departmental education on patients right's related topics pertinent to their staff. (For example, Pain Management, Communication Aids, Restraints)• Medical Staff receive the Code of Conduct during each credentialing cycle.
<p>Complaint and grievance process.</p> <ol style="list-style-type: none">1. Signage explaining how a patient can file a complaint internally, to DOH, to The Joint Commission and to Office of Civil Rights is posted at all primary facility entrances, in the Emergency Department and in all Financial Counseling offices.2. Patient Safety reviews all patient grievances. Patient Safety and staff receive patient grievances directly from the patient/family or other external sources. Patient Safety will communicate and provide necessary support to the unit manager for completion	<ul style="list-style-type: none">• Patient Safety• Involved managers

of follow up investigation, patient correspondence and resolution. See related policy "[Patient Complaint and Grievance Policy](#)"

Patient Rights and Responsibilities: Providence wants to ensure that both patients and Caregivers have a clear understanding of patients' rights and responsibilities. **The following rights and responsibilities appear in the brochure "Helpful Information for Patients and Families":**

As a patient at Providence Northwest Washington Region, you have the following rights:

- To be treated with courtesy, dignity and respect by all staff.
- To privacy during discussions about your care, exams and treatments.
- To have someone you choose and your care provider informed promptly that you have been admitted.
- To take part in your care and solving problems.
- To have your personal, cultural and spiritual values and beliefs supported when making a decision about treatment.
- To an interpreter or translator if English is not your primary language.
- To communication aids if you are deaf, hard of hearing, have trouble seeing, have trouble understanding or have a speech problem. We will communicate in a way that meets your needs.
- To have any person you choose be with you
- To supportive care and comfort, including pain management.
- To make informed decisions about your care, either by you or your representative.
- To refuse any procedure, drug or treatment and be informed of possible results of your decision. If you are asked to take part in a research study, you may refuse. It will not affect your medical care in any way.
- To involve family members, significant others or a legal designee in your care decisions.
- To receive care in a safe setting.
- To take part in planning for when you leave the hospital and learn about the care you will need.
- To be free of restraints unless they become necessary to protect you, patients or others from immediate harm and will be discontinued as soon as your behavior no longer poses a safety threat.
- To protection from abuse and neglect.
- To access protective services.
- To have your advance directives or living will honored if you are unable to make decisions about your care. If you have an advanced directive, your wishes such as not receiving life sustaining treatments, will be honored. For more details, ask for the booklet *Your Life, Your Decisions* at any registration desk.
- To end-of-life care.
- To donate organs and other tissues.
- To be told about unexpected outcomes of care, treatment and services.
- To have all communications and records related to your care kept confidential.
- To have access to your medical records, request amendments to your records and obtain information about disclosures of your health information, in accordance with applicable law.
- To be able to receive your medical records in a reasonable period of time.
- To receive accurate information about your bill and receive an explanation of the charges regardless of how you pay for your care
- To receive information about our policies, rules or regulations applicable to your care
- To no discrimination against you or your visitors based on race, color, religion, sex, age, national origin, sexual orientation, disability, source of payment and other factors in admission, treatment or participation in Providence's programs, services, activities and visitation.
- To use service animals in public areas of the hospital.

- To talk about any complaints about your care without fear of getting poor treatment. To have your concerns reviewed in a timely manner and, when possible, resolved in a timely manner, call our Patient Feedback Hotline at 425-261-3927 ☎☎☎☎☎☎ or by write to the Providence Northwest Washington Region.

Patients also have the right at any time, whether or not they file a grievance with the Medical Center:

- to file a grievance with the Washington State Department of Health by calling 1-800-633-6828 ☎☎☎☎, or by writing to them at: PO Box 47857, Olympia, WA 98504.
- The patient or their representative may file a grievance about **suspected discrimination** by contacting: Providence's Civil Right Coordinator at 1-844-469-1775 ☎☎☎☎, interpreter line 1-888-311-9127 ☎☎☎☎, or emailing Nondiscrimination.WA@providence.org, or mailing Civil Rights Coordinator, 101 W. 8th Avenue, Spokane, WA 99204. Locally, any member of the Compliance department may be contacted, including Theresa Bervell at 425-261-4538 ☎☎☎☎ or Lisa George at 425-261-3929 ☎☎☎☎.
- To contact The Joint Commission's Office of Quality Monitoring to report any concerns or register complaints by either calling 1-800-994-6610 ☎☎☎☎ or www.jointcommission.org.
- For Medicare patients to request that the Medical Center refer their grievance to an outside review organization.

Patients have the following responsibilities:

- To be as accurate and complete as possible when providing medical history and treatment information.
- To provide written medical advance directives or a living will, if they have one, to the Medical Center, their physician, and their family.
- To participate in decisions concerning their health care.
- To consider their physicians advice regarding their health care needs.
- To inform their physician or nurse if they have questions or concerns regarding their treatment.
- To discuss pain expectations and relief options with caregivers, and assist in the measuring and reporting of pain.
- To abide by Providence Northwest Washington Region policies.
- To be considerate of Providence Northwest Washington Region Caregivers and other patients and their privacy.
- To examine their bill and ask questions regarding charges or methods of payment.
- To be responsible for providing appropriate information for insurance claims and, when necessary, for working with Medical Center Caregivers to make payment arrangements.

Reference Document

[Patient Rights and Responsibilities Policy](#)

Referenced Documents

Reference Type	Title	Notes
Documents referenced by this document		
Referenced Documents	Comparison of Patient Rights Policy to Requirements	
Applicable Documents	Do Not Resuscitate/ No Code/	

Applicable Documents		
Referenced Documents	Patient Complaint and Grievance Policy	
Referenced Documents	Patient Rights and Responsibilities	Patient Rights and Responsibilities
Applicable Documents		
Referenced Documents	Patient Rights and Responsibilities Policy	Patient Rights and Responsibilities
Referenced Documents	www.jointcommission.org	
Documents which reference this document		
Applicable Documents	Comparison of Patient Rights Policy to Requirements	
Applicable Documents	Communicating with Limited English Proficiency Patients	
Referenced Documents	Patient Rights and Responsibilities Policy	
Lucidoc_Number: AD4000		
Attachments:		No Attachments
Approval Signatures		
<hr/>		
Approver	Date	
Lisa George: Sr Dir Quality Med Staff Svcs	09/2017	
Theresa Amihere Bervell: Compliance Privacy Mgr Nwr	08/2017	
<hr/>		
Applicability		
<hr/>		
WA - NWR Providence Medical Group, WA - Providence Regional MC Everett		



Implementation:	03/2014
Effective:	08/2018
Last Reviewed:	08/2018
Last Revised:	08/2018
Next Review:	08/2021
Owner:	<i>Kim Williams: Chief Executive Officer</i>
Policy Area:	<i>Hospital Administration</i>
References:	
Applicability:	<i>WA - Providence Regional MC Everett</i>

Visitor Guidelines

Scope:

This policy applies to caregivers (all employees) and representatives of Providence Regional Medical Center Everett.

Purpose:

Consistent with our Mission and core values, to provide guidelines on patient visitation that best meets the needs of patients in our care. In keeping with our vision statement, visitors are an integral part of patient care and support. High-quality, compassionate patient care is our first priority and will be the primary goals in establishing visitation guidelines. Providence Regional Medical Center Everett is committed to partnering with patients and their loved ones to create a patient-centric experience.

Definitions:

Support person: An individual who is in a support role for a patient or who is legally responsible for making health care decisions on behalf of a patient. This may include family members, friends or another individual who is there to support the patient. The role of a support person is not limited to a relationship that is legally recognized in Washington. The designation of a support person is not intended to supplant Washington law concerning the patient's legal representative.

High-risk visitor: Includes but is not limited to a person on the hospital campus visiting patients or caregivers with a history of criminal violence or sexual abuse; or who is classified as a sexual offender or has a history of domestic violence; or who is making threats against the safety of a patient, caregiver or other representative; or a person who actively interferes with a patient's medical care.

Policy:

To ensure a healing environment and to protect our patients and caregivers:

- Visitors are asked to always be respectful of other patients, caregivers and the property of Providence Regional Medical Center Everett.
- For the safety and well-being of everyone on campus, visitors must comply with all posted signs and warnings on the facility campus.
- A caregiver on the health care team may impose visiting restrictions when they are deemed essential for

the health and well-being of a patient.

- When patient care or safety is affected, visitors may be asked to leave a patient room at the discretion of the caregiver.
- Visitors with symptoms of illness, such as cold, cough, fever, open wounds, or other illness/disease that poses a risk may not be permitted to enter any patient care area.
- Visitors must follow infection control isolation protocols as outlined in Providence Regional Medical Center Everett policies.
- Visitors of patients in isolation care must comply with stated requirements, such as wearing gloves, gown and mask, when in a patient's room.
- Visitors who are identified as "high risk," as defined in this policy may be asked to follow an appropriate visitation plan that outlines visitation requirements and/or restrictions up to and including no visitation or access to the facility.
- Visitors who become loud, disruptive, or who are lingering in hallways or restricted areas may be required to leave the facility.
- Visitors may not bring non-prescribed medications or alcohol into a patient room.
- Visitors may not bring guns or weapons into the facility (with the exception of on-duty and off-duty law enforcement).

A family member or support person may stay overnight in a patient room if approved in advance by the attending nurse. Out of respect for other patients, if a patient is in a semi-private room, visitors are encouraged to make other accommodation arrangements.

In the event of a pandemic event, such as widespread influenza, hospital visitation may be limited based on recommendations of the local county health department.

Defining family and significant others

When a patient is not able to designate who may visit, the care team may need to work with the patient's designated support person to determine visitation.

- A surrogate decision maker appointed in compliance with Washington state law may exercise the patient's right to designate visitors.
- Oral designation of a support person, regardless of the support person's legal status, is sufficient to establish the person who will designate visitation rights on the patient's behalf.
- Written confirmation of a designation is not required by Providence Regional Medical Center Everett.

When a patient has not designated visitors or a support person and becomes incapacitated, the attending nurse will consult with the charge nurse to identify appropriate visitors. Decisions can be based on the patient's previous visitors and understood preferences and acceptable documentation, such as:

- Advance directive information
- Marital relationship/status
- Existence of other legal relationship: parent-child, civil union, marriage, domestic partnership
- Shared residence
- Shared ownership of property or business
- Acknowledgement of a committed relationship, such as an affidavit

After hours

Visitors may visit during regular visitor hours. Permission from the attending nurse is required in order to stay beyond regular visitor hours. A visitor badge may be required for after hours visitation. Refer to Providence Regional Medical Center Everett procedures.

Inmates in care

For patients in custody, all visitors and calls will be directed through the law enforcement official attending the patient.

Infants

Infants may room-in with a hospitalized mother provided a second responsible adult also remains with the mother and infant. When needed, Providence Regional Medical Center Everett can provide a bedside bassinet. Hospital caregivers are not responsible for the safety, security, care, feeding, or supply needs of the infant who is not under the care of our facility.

Minor children

A legal parent or guardian is authorized to identify visitors on behalf of minor children who are patients.

Minor children visiting a patient should be accompanied by an adult at all times.

Referenced Documents

Reference Type	Title	Notes
Documents referenced by this document		
Applicable Documents	Animal Presence at PRMCE	
Applicable Documents	Hospital Visitors: Procedures	

Lucidoc_Number: 28255

Attachments:

No Attachments

Approval Signatures

Approver

Date

Kim Williams: Chief Administrative Officer 08/2018

Applicability

WA - Providence Regional MC Everett



Implementation:	10/2000
Effective:	09/2018
Last Reviewed:	09/2018
Last Revised:	09/2018
Next Review:	09/2020
Owner:	<i>Lisa George: Sr Dir Quality Med Staff Svcs</i>
Policy Area:	<i>Compliance</i>
References:	
Applicability:	<i>WA - Providence Regional MC Everett WA - NWR Providence Medical Group</i>

Consent for Treatment

SCOPE:

All providers and caregivers within Northwest Washington who are involved in the patient consent process.

PURPOSE:

To provide guidance in regards to the informed consent process, including the roles and responsibilities of the treating provider as well as Providence caregivers.

To describe the procedures for:

- Verifying and documenting the patient's consent for a procedure on the Consent for Operation or Procedure form;
- For handling special situations such as patients with limited English proficiency or emergency situations.
- Identifying the persons authorized to consent to a procedure.

DEFINITIONS:

- **General consent:**
 - For PRMCE: General consent is obtained when the patient, or if the patient is legally incompetent to consent, the patient's legal representative signs under the conditions of admission listed on the registration form used in the admitting process. A blood count is an example of a "simple and common" procedure which is included in the general consent. General consent for care and treatment must be obtained from an adult patient with decision-making capacity or (if the patient is incompetent to consent) a person legally authorized to consent on behalf of the patient .
 - For PMG: General consent is obtained when the patient or (if the patient is incompetent to consent) the patient's legal representative signs during the registration process. General consent for care and treatment must be obtained from an adult patient with decision-making capacity or (if the patient is incompetent to consent) a person legally authorized to consent on behalf of the patient .
- **Informed consent:** A patient is given (in a language or means of communication he/she understands) the information needed in order to consent to a specific procedure or treatment which is known to have significant risks associated with it. If the patient lacks decision making capacity, or is deemed legally incompetent, the same applies to the patient's surrogate decision maker. It must be presented by the LIP

doing the procedure, except in those unique circumstances, such as a PICC line placement where the team member responsible for doing the procedure would be responsible for obtaining the informed consent. As a general rule, the LIP is responsible for obtaining informed consent; there is one exception to this rule; The RT receives informed consent on behalf of the radiologist for CT studies with contract and must include the discussion of the risks, benefits, alternatives and the alternative of not doing the procedure or treatment.

- Lack of decision making capacity.
- Competency
- **Invasive Procedures:** Invasive procedures are defined by Medical Staff Bylaws Section 11.3 (See Appendix C for a more comprehensive list.)
- **Licensed Independent Practitioner (L.I.P.)** An L.I.P. is a health care provider licensed by the state of WA and duly qualified to provide independent care in the hospital. M.D.'s, D.O.'s, ARNP's and midwives are L.I.P.'s. Note: although Physician Assistants are not L.I.P.'s, they are able to provide patients with informed consent for procedures that they will perform under the sponsorship of a physician.

POLICY STATEMENT:

Caregivers will take all reasonable steps to assure the necessary consents for admission, hospital, and medical treatment are obtained in writing from the patient (or his/her legal representative) in accordance with the applicable standards, regulations, and laws of the State of Washington.

1. **A general consent** is included on the conditions of admission form. This general consent is obtained in writing (whenever possible) from the patient or (if the patient is incompetent to consent) his/her legal representative by the hospital staff at the time of admission or registration for hospital services.
2. **Informed consent is required for procedures or tests that are complex, invasive, and/or involve the risk of serious injury**, e.g., blood transfusions, chemotherapy, surgery, anesthesia or analgesia, or non-routine diagnostic procedures such as myelograms, arteriograms, and pyelograms. Appendix C provides a list of many procedures that should be considered to be "invasive".
3. **Responsibility of the Licensed Independent Practitioner (L.I.P.)**. The L.I.P is responsible for identifying and explaining the procedures requiring informed consent to the patient as well as documenting that the patient has given informed consent. L.I.P.'s are responsible for disclosing to their patients information that they know, or should know, would be regarded as significant by a reasonable person in the patient's condition and circumstances in order for the patient to accept or reject the proposed treatment or procedure. The explanation should include:
 - a. The nature of the treatment or procedure;
 - b. The risks, complications, and expected benefits or effects of the treatment or procedure;
 - c. Any alternatives to the treatment or procedure and their risks and benefits; the risks and prognosis if the procedure is not done.
 - d. Who will actually perform the procedure
4. **Responsibility of the anesthesia/sedation physician**. If anesthesia or sedation is to be provided, the anesthesia or sedation physician must determine that the patient has been informed and acknowledges an understanding of the risks and consequences associated with the administration of anesthesia or sedation.
5. **Hospital staff's role**. The hospital staff's role in the informed consent process is to verify the patient's informed consent has been obtained by the responsible practitioner prior to performance of any invasive procedures. This verification is obtained in writing by the hospital staff whenever possible using the

"Consent for Operation, Treatment or Procedure" form prior to the surgery or procedure.

6. **Failure to obtain the patient's consent** in accordance with applicable legal standards may result in a charge of battery, negligence, and/or unprofessional conduct.

GENERAL PRINCIPLES OF CONSENT

1. **Who May Consent to a procedure/treatment?**

See Appendix A: Who may give an informed consent? for more information regarding whether a patient can be deemed "competent" for purposes of giving consent.

- a. **Competent Patient.** If the patient is competent, the patient has the right to consent to, or refuse, treatment. (See Appendix A)
- b. **Minor/Incompetent Patient.** If the patient is incompetent, either as set forth by law (for example, because the patient is a minor), or by reason of a condition (for example, the patient is unconscious or demented), the determination of who may consent depends upon whether a third person has the legal capacity to consent to treatment on behalf of the patient.
- c. **Patient should be alert and oriented.** In addition to being competent, a patient must also be alert and oriented in order to consent to or refuse treatment.
 - i. Reasonable effort should be made to obtain consent **prior** to the administration of a narcotic.
 - ii. If a patient appears alert and oriented but has received a narcotic recently that could affect the patient's judgment, then exploratory questions of the patient should be asked to test for alertness and orientation before obtaining the patient's consent.
 - I. Suggested questions include: "Can you please tell us your name and today's date? Please explain what procedure is being done today" or "Please explain why you are being treated today".
 - II. If the patient's appearance, mannerisms and/or responses to such exploratory questions do not support an alert and oriented state, then a third person who has the legal capacity to consent to treatment should complete the consent. Document observations and verbal responses in support of an alert and oriented state if it is questionable.

2. **Communication Issues**

- a. **Limited English Proficiency Patients**
 - i. A L.I.P obtaining informed consent is responsible for determining whether their patient's or patient's lawfully authorized representative's preferred language is English.
 - ii. If the preferred language is **not** English, all consent discussions must take place in the language of preference of the patient or lawfully authorized representative with the assistance of an interpreter.
 - iii. Whenever possible, a professionally trained interpreter should be used. Refer to "[Interpreter Services](#)" policy and check the Northwest home page for information about [interpreter services](#).
- b. **Patients with Other Communication Barriers** - arrange for consent discussions to take place using a communication modality in which the patient is fluent.
 - i. For the blind, verbal translation in the appropriate language is normally sufficient.
 - ii. For the deaf, written communication or sign language through a professionally trained medical interpreter may be used. A deaf person may indicate that they require a sign language

interpreter and they should be given the same consideration as a patient with limited English proficiency.

iii. Other handicap manifestations such as muteness should be dealt with appropriately.

c. **Documentation of interpreter Services**

i. Enter in Epic who acted as interpreter and the language used.

ii. At top of the consent form, check that a certified medical interpreter was used.

iii. For pre-translated Consent Forms, the patient and witness will sign the form in the language of the patient. The English version of the form will be attached and kept as part of the permanent medical record.

3. **Consent by Telephone, Telegram, Facsimile or Letter**

a. Consent for medical or surgical treatment should be obtained by telephone, telegram, facsimile, or letter only if the person(s) having legal capacity to consent for the patient is not available in person.

b. Consent by telephone should be witnessed by 2 people, at least one of whom must be licensed. The witnesses will remain on the line during the consent conversation. Both of these witnesses to the consent conversation will sign and note date and time of the conversation in the appropriate section of the consent form.

c. In situations in which the consent is granted either by telephone, letter, facsimile, or telegram, the documentation in the medical record must be sufficiently extensive to explain why consent was obtained in this manner.

PROCEDURE

1. **Documentation by L.I.P that Informed Consent has been Obtained** Documentation of the procedural L.I.P.'s communication with the patient will be documented by **one** of the following methods:

a. An informed consent document with risks, benefits, and alternatives included, and placed in the PRMCE chart, signed by the L.I.P.

b. The dictated report or progress note with risks, benefits, and alternatives included.

2. **Role of Hospital Staff Members in Verifying that Informed Consent has been Obtained**

Staff's role in the consent process is limited to verifying that the L.I.P. has obtained the patient's informed consent before the L.I.P. performs the procedure.

a. Verify that the patient understands the procedure and has had questions answered by the L.I.P.
Contact the L.I.P. if the patient appears to be uninformed about the procedure or has questions which need to be addressed before the procedure is started.

b. Obtain documentation of the patient's understanding by helping the patient to complete a PRMCE consent form.

c. Witness the signature of the patient or legal decision maker on the appropriate sections of the consent form.

3. **PRMCE's Consent for Procedure Form**

This form is completed for all patients undergoing an operation or invasive procedure at PRMCE and documents that a patient is consenting to an invasive procedure. The PRMCE Procedural Consent form should be signed and witnessed at PRMCE prior to the procedure but after the L.I.P. has completed the informed consent process. The form has two unique sections:

1. Consent for Procedure.
 - i. Complete the name of the procedure based upon the written order of the proceduralist. Procedure names must be written in full; abbreviations are not acceptable.
 - ii. Complete the name of the provider who will do the procedure.
2. **Consent for transfusion of blood** and blood components.
 - i. **Process if Patient Refuses to Give Consent for a Transfusion.** If the procedural L.I.P. has discussed transfusion with the patient but the patient refuses to give consent for a transfusion then PRMCE staff should take the following steps:
 - I. Offer flier "Frequently asked questions about blood transfusion".
 - II. Have patient sign refusal option on consent form and witness.
 - III. Ask the patient to read & sign the "Release of Liability regarding Refusal of Blood Products" form.
 - IV. Contact the L.I.P.
 - V. Notify the department in the event a procedure will be delayed.
 - VI. Notify Blood Conservation Management Specialist.
 - ii. If the patient is receiving only a transfusion, a separate "Consent for Transfusion of Blood and Blood Components" #35230 may be used.

4. **Patient Confirmation/Witnessing/Copies**

All PRMCE Consent forms should be signed and witnessed at PRMCE, prior to the procedure but after the L.I.P. has completed the informed consent process

- a. **Patient's Signature.** After consideration of the information provided by the L.I.P., including an opportunity to ask questions, the patient (or his/her legal decision maker) should indicate their consent on each appropriate section of the consent form by signing at the bottom of the page. The date and time of signing should also be recorded, along with the signature of a witness.
- b. Expand this section to include patients without decision making capacity
- c. **Witnessing.** Generally, PRMCE staff serve as witness to the patient's signature but the witness may also be an L.I.P. Each section of the form may be witnessed separately.
- d. **Copies.** A copy of the consent form(s) signed by the patient (or his/her legal representative) may be given to the patient (or his/her legal representative) if they request it. A copy of the original signed consent form(s) shall be scanned in the patient's medical record..

5. **SPECIAL CIRCUMSTANCES IN WHICH A L.I.P IS NOT REQUIRED TO OBTAIN FULL INFORMED CONSENT**

There are two special circumstances in which a L.I.P. is not required to disclose all of the information that is required to secure the patient's informed consent.

- a. **Therapeutic privilege.** When the L.I.P. believes that fully informing the patient is not medically sound, because such a disclosure poses a serious threat to the patient, the L.I.P. may withhold the informed consent process.

Exercise of the therapeutic privilege requires the documented concurrence of a consulting L.I.P. who should not be directly involved in the patient's care. In addition, consultation from psychiatry and/or from the Ethics Committee may also be helpful.

Both L.I.P.'s should document in detail:

- i. The rationale for withholding the disclosure of the material information;
 - ii. The material information disclosed to the patient;
 - iii. Any material information not disclosed to the patient;
 - iv. What material information was disclosed or not disclosed to the closest relatives; and
 - v. That approval was secured for proceeding with the treatment or procedure when full disclosure to relatives was made.
- b. **Patient requests not to be informed.** Where the patient requests that he/she not be informed of the risks, etc. of a particular treatment or procedure, the L.I.P. should fully document in the patient's medical record the facts that resulted in this conclusion and that the patient has decision-making capacity. The L.I.P. should also document what, if any, information was disclosed to the patient.

6. EMERGENCY TREATMENT

When a delay in treatment would jeopardize the life or health of the patient and the patient is unable to give an informed consent, the law recognizes an exception to the requirement for obtaining an informed consent.

- a. **Attempt to Obtain Consent.** If at all possible, an attempt to obtain consent for the medical or surgical treatment should be made. If written consent from the patient or his/her legal representative is impossible, verbal consent or consent by telephone in emergency situations may be utilized.
- b. **Certification of Emergency.** Before emergency treatment is provided without obtaining consent, the attending L.I.P. shall determine that the treatment appears to be immediately required and necessary to prevent deterioration or aggravation of the patient's condition. This determination shall be charted by the L.I.P.
- c. **Treat Only the Emergency.** In proceeding without consent, only the required and necessary emergency medical care shall be performed. Unnecessary incidental treatment should be delayed until an attempt to obtain consent from the patient or his/her legal representative is made.
- d. **Knowledge of Facts Negating Consent.** The emergency care shall not be provided if the L.I.P. has knowledge of facts negating consent, e.g. an expression of religious beliefs or a valid Advanced Directive or Living Will.
- e. **When in Doubt.** When in doubt as to whether the consent is available or valid or the procedure necessary to save a life, err on the side of saving a life.
- f. **Consent for Procedure Form.** If the LIP has determined that an emergency treatment is warranted, the "Emergency Consent Exception" box can be checked on the Consent for Procedure form in lieu of obtaining signed consent.

7. REFUSAL TO ACCEPT TREATMENT OR TO SIGN A CONSENT FORM

- a. If a patient or his/her legal representative refuses procedures advised by the attending L.I.P. or refuses to sign the consent form.
 - i. Attempt to resolve the patient's issues/concerns. Notify their L.I.P. who may be able to address the patient's concerns.
 - ii. Follow the steps outlined in the policy [Leaving Against Medical Advice and Patients Restricted From Discharge](#) and document the refusal on the Refusal of Examination, Advised Medical

Care, or Transfer form.

- iii. The progress note should include a description of the nature of the refusal, the fact that the patient was informed of the possible consequences of a refusal and the fact that the patient or his/her representative persisted in the refusal.

8. DURATION OF CONSENT

- a. **A Consent to a Medical Treatment or Procedure** is valid until the patient revokes the consent (verbally or in writing) or until the patient is discharged from the hospital, unless the consent form expressly states otherwise. A new consent is necessary:
 - i. if a change in a patient's condition requires a new procedure or
 - ii. if the risks or benefits of the procedure materially change as a result of the change in condition or
 - iii. the patient has a second, identical procedure during the same stay.
- b. **Consent for Blood Transfusion** is valid for only 30 days, or one admission, whichever comes first. Repeat transfusions are covered under the same Consent for Blood Transfusion if the transfusions are within a single admission or within 30 days.

9. Obtaining consent on an unidentified individual needing non-emergent treatment.

This process is to be used if a patient presents for treatment using an assumed or false name and we are unable to establish the true identity of the individual:

- a. Two witnesses along with L.I.P.(s) involved in the procedure should be present during consent discussions and both witnesses should sign the Consent for Treatment form and any Informed Consent documentation that the L.I.P. may have.
- b. Get a photo of the person who signs the consent form (the "No Identity Patient"), the L.I.P., and witnesses. Security or Patient Safety can help with the photos. Place photos in the chart and make these part of the permanent record.
- c. Document in the medical record that we have no ID to prove patient is who s/he claims to be.
- d. Add a dictated or handwritten addendum to consent document(s) stating something like "Patient presented under this name, with this diagnosis; appearance was _____. We think there is an identity issue and have shared this with the patient, but above patient states s/he is above patient and gives full consent for this procedure in the presence of these witnesses."
- e. **Elective procedures:**
 - i. If procedure is elective, it may be held pending an attempt to obtain appropriate identification. Clinical staff should work with the Administrative Supervisor/Patient Safety staff to try to get identification before proceeding to next steps. Security can assist with ID process as necessary.
 - ii. Patient safety issues to consider: are the diagnostic tests and history and physical for the presenting patient or from another individual? Do we have correct allergy information?
 - iii. Do the benefits of proceeding with the elective procedure outweigh the risks associated with doing an elective procedure on an individual?
 - iv. L.I.P. will make the decision as to whether or not the procedure will move forward and may choose to work with his/her personal risk manager in making the decision.

Appendix A: Who may give an informed

consent?

1. Adult Competent Patient

An adult competent patient must sign his/her own consent/refusal to consent documentation. ***If an adult competent patient is able to provide consent, no one else may provide substituted consent***, except a court of competent jurisdiction. ([RCW 26.28.010 Age of majority](#), [RCW 26.28.015](#)).

- a. **Definition of Adult.** An adult is a person who is 18 year or older, or who has legally married (regardless of a subsequent divorce or annulment).
- b. **Competency.** A patient may be considered to be mentally competent until such time as evidence to the contrary becomes obvious or known. A person lacks legal capacity to provide informed consent if they are unable, for any reason, to appreciate the information provided by the L.I.P. as to the decision on treatment, or to exercise his/her judgment. The patient must be of sound mind and not under duress. The consent should first be read by or read to the patient. The patient should know what is being signed. If in the judgment of the attending L.I.P., the patient is not considered to be of sound mind or mentally competent, as after a head injury, or when under the influence of drugs or alcohol, or when sedated, treatment must be deferred or consent from an authorized representative must be obtained, unless there is an emergency. (See [RCW 11.88.010](#) for a discussion of legal incompetence).
- c. **Incompetency.** A patient may have been declared incompetent by a court, in which case a guardian will normally have been appointed to make a decision on behalf of the competent patient. In cases where the patient has not been declared as incompetent by a court, the attending L.I.P. should determine whether the patient is incompetent at the time the consent is sought to be obtained. The fact that the patient has made a medically irrational choice, or a choice with which most people would disagree, does not in and of itself warrant the conclusion that the patient is incompetent. A patient may also be incompetent at one point in time and not at another. Medication of a patient or severe pain may, but does not necessarily, cause a patient to become temporarily incompetent. The question is whether the pain or medication substantially interfere with the patient's ability to understand the information being provided or exercise responsive judgment.
- d. **Persons Authorized to Provide Informed Consent to Health Care on Behalf of Adult Incompetent Patient.** Persons authorized to provide informed consent to health care on behalf of an adult patient who is incompetent to consent shall be a member of the following classes of persons in the following order of priority per [RCW 7.70.065](#):
 - i. The appointed guardian of the patient, if any;
 - ii. The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions;
 - iii. The patient's spouse or state registered domestic partner;
 - iv. Children of the patient who are at least 18 years of age;
 - v. Parents of the patient; and
 - vi. Adult brothers and sisters of the patient.
- e. **Persons in custody of the Law.** A person in custody of a law enforcement agency must still give consent for medical treatment; except in the case of alcohol or drug blood tests. Under certain circumstances consent is implied (Drivers Implied Consent Law [RCW 46.20.308](#)). See *Blood Alcohol Tests* in Appendix B for more details. If the person is unable to consent due to

incompetence, the surrogate decision makers are the same as outlined in the prior section.

2. **Minors – General Rules to Consent (see exceptions in Section 3 below)**

- a. An excellent one page summary of the primary areas related to minor consent is provided in the reference "Providing Health Care to Minors under Washington Law".
- b. **Definition of a minor:** A minor is any person under the age of 18 who is not or has not been legally married.
- c. *Informed consent discussions with minors should be conducted at a level that can be understood by the minor.*
- d. **Questions?** Any questions about whether a minor can consent to his/her own treatment shall be directed to the Patient Safety Department.
- e. **Persons authorized to provide informed consent to health care on behalf of a minor in the following order of priority per [RCW 7.70.065](#):**
 - i. The **appointed guardian**, or legal custodian authorized pursuant to Title [26](#) RCW, of the minor patient, if any;
 - ii. A **person authorized by the court** to consent to medical care for a child in out-of-home placement pursuant to chapter [13.32A](#) or [13.34](#) RCW, if any;
 - iii. **Parents** of the minor patient;
 - iv. The **individual, if any, to whom the minor's parent has given a signed authorization** to make health care decisions for the minor patient; and a **competent adult representing himself or herself to be a relative** responsible for the health care of such minor patient or a competent adult who has signed and dated a declaration under penalty of perjury pursuant to RCW [9A.72.085](#) stating that the adult person is a relative responsible for the health care of the minor patient. Such declaration shall be effective for up to six months from the date of the declaration.

PRMCE as the healthcare provider may, but is not required to, rely upon the representations or declaration of a person claiming to be responsible for the care of the minor child.

The provider may request documentation to verify the person's claimed status as being responsible for the care of the child. The practice at PRMCE is to request that anytime a child is brought for treatment by any relative other than the child's parent, the relative will be asked to complete a "[Declaration of Responsibility for a Minor's Health Care](#)" form ESI #37148 which is available from the Print Shop and in Patient Care Forms.

A healthcare provider who relies upon the declaration of a person who claims to be responsible for the child is immune from liability in any suit based upon reliance.

3. **Exceptions to the general rules regarding consent to minors are noted below.**

1. **The reference "Providing Health Care to Minors under Washington Law" discusses special consent situations related to:**
 - i. Emergency Medical Services
 - ii. Non-emergency medical services under the Mature Minor Doctrine.
 - iii. Immunizations

- iv. Sexually Transmitted Disease Testing
 - v. Birth Control Services
 - vi. Prenatal Care services
 - vii. Outpatient and inpatient mental health
 - viii. Outpatient and inpatient substance abuse treatment.
2. **Emancipated Minors.** If emancipated, a minor may give consent. A minor who obtains a court order declaring emancipation may give consent (RCW [26.28.020](#)). Absent a court order, there is no clear definition of an "emancipated" minor. The L.I.P. obtaining such consent must weigh the facts in making any such determination. Age, maturity, intelligence, training, experience economic independence and freedom from parental control are the factors which the Washington courts have stated must be considered (**Smith v. Seibly**, 72 Wn2d 16). When seeking consent of a minor for medical treatment, the L.I.P. should ask the minor questions to determine his/her capacity to understand the proposed medical treatment and should take careful notes of these questions and the minor's answers in order to document the maturity of the minor.
 3. **Married Minors.** A married minor (even one who has been divorced or whose marriage has been annulled) is considered an adult for purposes of providing informed consent or refusal to treatment. To prove marital status, the patient should furnish a copy of the marriage certificate. If the certificate is not furnished, the consent of the parent or guardian should be obtained if possible. The minor may also fit the exception for "emancipated" minor.
 4. **Minor with Divorced Parents.** The parent having legal custody has the final authority on consent issues, although the consent of either parent is sufficient. If there is a conflict between the parents, the one having legal custody shall make the determination. Regardless of the allocation of decision-making authority in the court order, either parent may make emergency decisions affecting the child's health.
 5. **Non-Abandoned Minor Who's Parents are Unavailable.** This situation usually arises where the minor is away from home or in the care, custody or possession of schools, camp, sitter, etc. The hospital will accept a written consent by the minor's parent or legal guardian that such person in the care, custody or possession of the minor patient, can give consent. Also, note that consent may be implied in an emergency room.
 6. **Minors Deserted or Abandoned by Parents.** It must first be established that the minor has been in fact abandoned or deserted by his/her parents. If so, then the matter should be referred to Patient Safety for an opinion as to who may properly give consent. Also, refer to the policy on reporting child abuse or neglect. Child Protective Services (CPS) should be contacted if there is a reasonable belief of abandonment, neglect or abuse.
 7. **Minor Placed for Adoption.** In an agency adoption, when the agency has obtained a relinquishment from the natural parent, then the agency may consent. If a private placement, the hospital should obtain consent from the natural parent and if possible, from the prospective adoptive parents.
 8. **Minors Who are Patients/Children of Minors.** A minor parent has the same right as any other parent to provide consent on behalf of his/her minor child, provided the minor is not so young or immature as to be incapable of giving informed consent.
 9. **Minors in Government/Foster Care.** For children in the custody of foster parents or other placement pursuant to state action or court order, DSHS or the supervising governmental entity shall provide consent to non-emergency procedures.

10. **Minors on Active Duty with United States Armed Forces.** A minor who is serving on active duty with any branch of the United States Armed Forces may consent for hospital, medical or surgical care without having to obtain parental or guardian consent.

4. **Surrogate Decision Makers**

- a. **Duty of Surrogate Decision-Maker.** Before any person authorized to provide informed consent on behalf of an incompetent patient exercises that authority, the person must first determine in good faith that the incompetent patient would consent to the proposed health care. If such a determination cannot be made, the decision to consent to the proposed health care may be made only after determining that the proposed health care is in the patient's best interest.
- b. **Priority of Surrogate Decision-Makers.** If the L.I.P. or other person seeking informed consent for proposed health care of the patient makes reasonable efforts to locate and secure authorizations from a surrogate decision-maker in the first or succeeding class and finds no such person available, authorization may be given by any person in the next class in the order of descending priority. However, no person under this section may provide informed consent to health care if:
 - i. A person of higher priority under this section has refused to give such authorization or;
 - ii. There are two or more individuals in the same class and the decision is not unanimous among all available members of that class.
- c. **Proof of Guardianship.** Proof that a person is the appointed guardian of the patient shall be through provision of Letters of Guardianship issued by a court. If the Letters of Guardianship say that the guardian is a limited guardian, a true copy of the Order appointing the guardian should be examined to determine the limitations on the guardian's authority, to insure that the guardian has authority to make decisions "for the person" of the incompetent as well as for his/her financial estate. For Letters of Guardianship issued more than six (6) months prior to presentation, the health care provider may want to require proof of continued authority by requiring a current copy certified by the issuing Court.
- d. **Power of Attorney.** The power of attorney document must be examined carefully to insure that it is a "durable" power of attorney which states that it survives the incompetency of the patient, and also that it expressly grants authority to the attorney in fact to make health care decisions. Unless he/she is the spouse, adult child, parent or brother or sister of the principal, none of the following persons may act as the attorney in fact for the principal: any of the principal's L.I.P.'s, the L.I.P.'s employees or the owners, administrators or employees of the health care facility where the principal resides or receives care.
- e. **Limitations on Authority of Guardian/Attorney in Fact to Provide Surrogate Consent.** Both guardians and attorneys in fact under a power of attorney may **not** consent to the following health care procedures without prior court order:
 - i. Therapy or other procedure which induces convulsion.
 - ii. Surgery solely for purposes of psychosurgery;
 - iii. Amputation (may include certain surgeries to entirely remove diseased organs);
 - iv. Other psychiatric or mental procedures which are intrusive on the person's body integrity, physical freedom of movement, or the patient's "bill of rights" (see [RCW 71.05.360](#)) or;
 - v. Involuntarily commitment for mental health treatment, observation or evaluation, unless the procedures for involuntary commitment are followed.
- f. **Guardian Ad Litem; Pending Guardianship Proceeding:** A guardianship is initiated by some

interested person filing a petition in the Superior Court of the State of Washington. Upon filing the petition, a guardian ad litem is appointed on the determination of whether the person is incompetent and who the guardian should be. Guardian ad litem do not have the broad authority of a guardian. A guardian ad litem may not consent to discretionary of non-essential health care treatment; the court appointed guardian ad litem only has the authority to provide consent to emergency lifesaving medical services on behalf of the alleged incompetent or disabled person.

- g. **Standby Guardian.** A standby guardian is a person appointed by a regularly appointed guardian, to serve as guardian in the event of incapacity or unavailability of the court appointed guardian. The standby guardian shall have the authority to provide timely, informed consent to necessary medical procedures if the regular guardian cannot be located within four (4) hours after the need for such consent arises. The name, address and telephone number of the standby guardian should be in the court file for the guardianship proceeding.
- h. **Unusual or doubtful situations?** Contact the Patient Safety Department for assistance in determining who may sign, or if a court order is necessary to permit the procedure to be performed. For an emergency, consent is implied.

Appendix B - Special Informed Consent Requirements

Various laws or regulations and certain circumstances impose special informed consent requirements.

1. **Blood Alcohol Tests:** The law implies consent by a patient to a blood alcohol test if certain conditions exist:
 - a. the patient was involved in an accident in which another person was injured;
 - b. there is a reasonable likelihood that the injured person may die as a result of his/her injuries and;
 - c. the patient is under arrest for the crime of driving under the influence of intoxicating liquor or drugs ([RCW 46.61.502](#)).
 - d. The hospital policy is to make a reasonable attempt to honor requests for blood alcohol specimens and tests for law enforcement agencies, provided the requesting law enforcement officer reads and signs the appropriate certification of foregoing circumstances. The hospital will agree to draw blood if undue restraint is not required. Where physical restraint is required, law enforcement agencies will have to provide restraint and, if deemed appropriate by the emergency room L.I.P., provide qualified professional personnel to withdraw blood for examination.
2. **HIV Testing:** The patient's informed consent for HIV testing is required, along with pre-and post-test counseling. In cases of occupational exposure to blood borne pathogens, both the exposed worker and the source patient must give consent for HIV testing of their blood. [WAC 246-100-207](#) allows the provider/lab to obtain either written or verbal informed consent prior to performing an HIV test. At PRMCE a patient may give consent before undergoing a procedure and the consent is documented in Section 1 of the Procedural Consent Form. See [Blood borne Pathogen Exposure Control Plan](#) for more details.
3. **Photography:** The likeness of a patient may be recorded through a number of visual means, including still photography, videotaping, digital imaging, scans, and others. The term "patient photography" will be used for any such recording of a patient's likeness.
 - a. Consent for patient photography used in the diagnosis or treatment of the patient is obtained via the standard conditions of admission form patients sign when admitted, as well as in the *Consent for*

Operation or Invasive Procedure form.

- b. Additional written authorization should be obtained before recording or filming any patient for purposes other than the identification, diagnosis, or treatment of that patient (such as medical education, staff teaching, or publicity purposes). The patient or his/her legal representative should sign and date the form "Patient Authorization for Marketing and Communications". For more details refer to the policy [Release of Information to the Media](#).

4. **Research Subjects:** All research, development, and related activities that involve human subjects, including informed consent requirements, must be reviewed and approved by the Institutional Review Board (IRB) prior to initiation of the activity. Specific written consent is required for each drug or device. In addition, drug manufacturers may provide specific consent forms. The particular consent form for each procedure, drug or device subject to these regulations and guidelines must be approved by the IRB.

The investigator, or sub-investigator designated by the investigator (as defined on Form 1572) must obtain the informed consent. Informed consent must be obtained before non-routine screening procedures are performed and/or before any change in the subject's current medical therapy is made for the purpose of the clinical trial, whichever comes first. The patient should have ample opportunity to ask questions and to decide whether or not to participate in the clinical trial. The patient should not be coerced to participate or continue in a trial. The patient (or legal representative) and the individual obtaining consent must personally sign, date and time the informed consent document which has been approved by WIRB. The patient or legal representative should receive a copy of the signed informed consent document and any subsequent amendments. In situations where the patient can only be enrolled with the consent of a legal representative, the patient should still be informed of the clinical trial compatible with their level of understanding. In addition to the legal representative, the patient should (if capable) sign, date and time the informed consent document following the explanation of the trial. For additional information regarding research-related requirements, consult [Standards of Practice - Clinical Research Department](#) policy.

5. **Autopsies:** For additional details regarding autopsies, see policy [Patient Death: Adult, Child or Fetal Demise](#).
 1. **Consent for autopsy.** Consents are to be obtained after expiration of adult or child. Autopsy may be requested by attending L.I.P., family, or ME. Autopsy permit is not required on ME's cases.
 2. The right to request or refuse an autopsy([RCW 68.50.101](#)) may be exercised by the following persons in the order of priority set out;
 1. the surviving spouse or state registered domestic partner;
 2. any child of the deceased individual who is 18 years of age or older;
 3. one of the parents of the decedent;
 4. legal-aged sibling;
 5. A person who was guardian of the decedent at the time of death
 6. Any other person or agency authorized or under an obligation to dispose of the remains of the decedent.
 7. Telegram is acceptable and/or phone authorization by two witnesses may be obtained.

6. **Disposition of Remains:**

- a. See revised code below

Persons authorized to make an anatomical gift — After donor's death.

Appendix C - List of Invasive Procedures

Invasive Procedures are defined per Medical Staff Bylaws. The following is not an exhaustive list. It is intended to clarify some procedures which have been questioned.

Procedure Name	Requires Informed Consent
Ablations	Yes
Amniocentesis	Yes
Angiogram	Yes
Angiography	Yes
Angioplasties	Yes
Arthrogram	Yes
Arterial Line insertion (performed alone)	Yes
Aspiration Cyst (simple/minor)	No
Aspiration Cyst (complex)	Yes
Blood Administration	Yes
Blood Patch	Yes
Bone Marrow Aspiration	Yes
Bone Marrow Biopsy	Yes
Bronchoscopy	Yes
Capsule Endoscopy	Yes
Catherizations, Cardiac & vascular	Yes
Cardioversion	Yes
Central Line	Yes
Chemotherapy	Yes
Chest Tube Insertion	Yes
Circumcision	Yes
Core Biopsy - (stereotactic or ultrasound guided)	Yes
Dialysis Catheter Insertion	Yes
Discogram	Yes
Endoscopies	Yes
Epidural Catheter for chronic pain mgmt.	Yes
ERCP	Yes
Feeding Tube (nasointestinal)	No

Fine Needle Aspiration	Yes
Fistulogram (Dialysis Shunt Angio)	No
Foley Catheter	No
Galactogram/Ductogram	Yes
HIV Testing	Yes
Procedure Name	Requires Informed Consent
I & D Abscess	Yes
IV Contrast Media	Yes
IV therapy	No
Joint Injection	Yes
Joint relocation with sedation	Yes
Lumbar Puncture	Yes
Lymphoscintigraphy	No
Myelogram	NO
Needle Localization mammogram	Yes
Non-OR Eye Laser Procedure	Yes
Paracentesis	Yes
Percutaneous aspirations & biopsies	Yes
Pericardial tap	Yes
Perinatal Blood Testing	Yes
PICC Line	Yes
Porta Cath Insertion	Yes
Radiation Therapy	Yes
RF Ablation	Yes
Sedation, deep	Yes
Sedation, procedural/moderate	Yes
Sinogram	Yes
Swan Ganz Line	Yes
Thoracentesis	Yes
TIPS (Transjugular intrahepatic portosystemic shunt)	Yes
TPA administration	Yes but not required when TPA is used to clear a line.
Transesophageal Echocardiograms (performed alone)	Yes
Tube Change (gastrostomy/PEG)	No

Tube Check (such as biliary tubes)	No
Umbilical Artery/Vein Line	Yes
Venipuncture	No
Ventricular tap	Yes
Vertebroplasty	Yes
Voiding Cystourethrogram	Yes
White Cell Study	Yes

68.64.080

Persons authorized to make an anatomical gift — After donor's death.

1. Subject to subsections (2) and (3) of this section and unless barred by RCW [68.64.060](#) or [68.64.070](#), an anatomical gift of a decedent's body or part may be made by any member of the following classes of persons who is reasonably available, in the order of priority listed:
 - a. An agent of the decedent at the time of death who could have made an anatomical gift under RCW [68.64.030](#)(2) immediately before the decedent's death;
 - b. The spouse, or domestic partner registered as required by state law, of the decedent;
 - c. Adult children of the decedent;
 - d. Parents of the decedent;
 - e. Adult siblings of the decedent;
 - f. Adult grandchildren of the decedent;
 - g. Grandparents of the decedent;
 - h. The persons who were acting as the guardians of the person of the decedent at the time of death; and
 - i. Any other person having the authority under applicable law to dispose of the decedent's body.
2. If there is more than one member of a class listed in subsection (1)(a), (c), (d), (e), (f), (g), or (h) of this section entitled to make an anatomical gift, an anatomical gift may be made by a member of the class unless that member or a person to which the gift may pass under RCW [68.64.100](#) knows of an objection by another member of the class. If an objection is known, the gift may be made only by a majority of the members of the class who are reasonably available.
3. A person may not make an anatomical gift if, at the time of the deceased individual's death, a person in a prior class under subsection (1) of this section is reasonably available to make or to object to the making of an anatomical gift.
 1. Subject to subsections (2) and (3) of this section and unless barred by RCW [68.64.060](#) or [68.64.070](#), an anatomical gift of a decedent's body or part may be made by any member of the following classes of persons who is reasonably available, in the order of priority listed:
 - a. An agent of the decedent at the time of death who could have made an anatomical gift under RCW [68.64.030](#)(2) immediately before the decedent's death;
 - b. The spouse, or domestic partner registered as required by state law, of the decedent;
 - c. Adult children of the decedent;

- d. Parents of the decedent;
 - e. Adult siblings of the decedent;
 - f. Adult grandchildren of the decedent;
 - g. Grandparents of the decedent;
 - h. The persons who were acting as the guardians of the person of the decedent at the time of death; and
 - i. Any other person having the authority under applicable law to dispose of the decedent's body.
2. If there is more than one member of a class listed in subsection (1)(a), (c), (d), (e), (f), (g), or (h) of this section entitled to make an anatomical gift, an anatomical gift may be made by a member of the class unless that member or a person to which the gift may pass under RCW [68.64.100](#) knows of an objection by another member of the class. If an objection is known, the gift may be made only by a majority of the members of the class who are reasonably available.
 3. A person may not make an anatomical gift if, at the time of the decedent's death, a person in a prior class under subsection (1) of this section is reasonably available to make or to object to the making of an anatomical gift

Lucidoc_Number: 10127

Attachments:

[Providing Healthcare to Minors](#)

Approval Signatures

Approver	Date
Lisa George: Sr Dir Quality Med Staff Svcs	09/2018

Applicability

WA - NWR Providence Medical Group, WA - Providence Regional MC Everett

Exhibit 17

Providence Regional Medical Center Everett Nondiscrimination Policy

Current Status: Active

PolicyStat ID: 3544694



Implementation: 11/2016
Effective: 04/2017
Last Reviewed: 04/2017
Last Revised: 04/2017
Next Review: 04/2022
Owner: Martha Raymond: Vp Risk Claims And Insurance
Policy Area: Compliance
Department:
Applicability: Providence Health & Services Systemwide

Nondiscrimination Policy, PROV-ICP-729

Subject: Nondiscrimination Policy and Grievance Procedure for Individuals Accessing Any Providence Health Program and/or Activity	Policy Number: PROV-ICP-729	
Department: Enterprise Risk Management Services	New Revised Reviewed	Date: 07/18/2016
Executive Sponsor: VP, Compliance and Information Security	Policy Owner: VP, Risk, Claims and Insurance	
Approved by: Michael Butler - President of Operations, Chief Executive, PH&S	Implementation Date: 07/18/2016	

Scope: This policy applies to Providence Health & Services and its Affiliates¹ (collectively known as "Providence") and their caregivers (employees); employees of affiliated organizations; members of System, community ministry and foundation boards; volunteers; trainees; independent contractors; and others under the direct control of Providence (collectively referred to as workforce members), with respect to their involvement in the provision of health program and/or activities offered by Providence. This policy does not apply to nondiscrimination in employment or in the provision of employee benefits by Providence, or in the provision of coverage through Providence Health Plan, which are covered by other policies (see end of Reference section below). This is a management level policy approved by Leadership Council and signed by the President of Operations, Chief Executive for Providence.

Purpose: To establish Providence's System-level policy and procedures prohibiting discrimination against individuals accessing any Health Program and/or Activity (defined below) provided by Providence, designating caregivers responsible for implementation and monitoring of this policy, and establishing the internal grievance procedure for complaints alleging discrimination related to a Providence Health Program or Activity.

In addition to this policy, Providence is committed to nondiscrimination in employment and in the provision of benefits to caregivers of Providence, and in the provision of coverage through Providence Health Plan. These commitments are more fully outlined in Providence's applicable Human Resources policies and benefit plan documents, or in the applicable Providence Health Plan policies. This policy is not intended to replace, substitute or modify: (1) Providence's and Affiliates' policies that prohibit discrimination in employment and provide for an internal grievance procedure for employment-related disputes; (2) any grievance procedure set forth in the applicable summary plan description for individuals participating in a Providence benefit plan; or (3) Providence Health Plan's policies governing nondiscrimination and associated grievance procedures in its

health-related insurance activities. For information on the latter policies and grievance procedures, please see links provided at the end of the Reference section below.

Definitions: For purposes of applying this policy, the following definitions apply:

1. Caregiver: Refers to all employees of Providence.
2. *Disability or Handicap:*
 - a. **In States Other than Washington:** Means with respect to an individual, a physical or mental impairment that, in Alaska, Montana, and Oregon *substantially limits*, or in California *limits*, one or more major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment, as defined in 42 U.S.C. 12102, as amended;
 - b. **In Washington:** Means the presence of a sensory, mental, or physical impairment² that: (i) is medically cognizable or diagnosable; or (ii) exists as a record or history; or (iii) is perceived to exist whether or not it exists in fact. Disability exists whether it is temporary or permanent, common or uncommon, mitigated or unmitigated, or whether or not it limits the ability to work generally or work at a particular job or whether or not it limits any other activity within the scope of RCW Ch. 49.60.
3. *Discrimination on the Basis of Sex:* Includes but is not limited to discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, gender or sex stereotyping, and gender identity.
4. *Gender Identity:* Means an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual's sex assigned at birth. The way an individual expresses gender identity is frequently called "gender expression," and may or may not conform to social stereotypes associated with a particular sex or gender. Stereotypical notions of sex or gender include notions of masculinity or femininity, including expectations of how individuals represent or communicate their gender to others via behavior, clothing, hairstyles, activities, voice, mannerisms or otherwise, and include gendered expectations related to the appropriate roles of a certain gender.
5. *Health Program or Activity:* Means the provision or administration of health-related services, and provision of assistance to individuals in obtaining health-related services or insurance coverage.³
6. *Limited English Proficiency:* Means an individual whose primary language for communication is not English and who has a limited ability to read, write, speak or understand English.
7. *National Origin:* Includes, but is not limited to, an individual's, or his or her ancestor's, place of origin (such as country or world region) or an individual's manifestation of the physical, cultural, or linguistic characteristics of a national original group.
8. *Qualified Bilingual/Multilingual Staff :* Means a caregiver who is designated by Providence to provide oral language assistance as part of the caregiver's current, assigned job responsibilities and who has demonstrated to the covered entity that he or she:
 - a. Is proficient in speaking and understanding both spoken English and a least one other spoken language, including any necessary specialized vocabulary, terminology and phraseology, and
 - b. Is able to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary languages.
9. *Qualified Interpreter for an Individual with a Disability:* Means an interpreter who via a remote interpreting service or an on-site appearance:
 - a. Adheres to generally accepted interpreter ethics principles, including client confidentiality; and

- b. Is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology (e.g., sign language interpreters).
10. *Qualified Interpreter or Translator for an Individual with Limited English Proficiency*: Means an interpreter or translator, respectively, who via a remote interpreting service or an on-site appearance:
- a. Adheres to generally accepted interpreter or translator ethics principles, as applicable, including client confidentiality;
 - b. In the case of an interpreter has demonstrated proficiency in speaking, and in the case of a translator has demonstrated proficiency in writing, and in both cases, demonstrates proficiency in understanding both spoken English and at least one other spoken language; and
 - c. In the case of an interpreter is able to interpret, and in the case of a translator is able to translate: effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.
11. *Section 1557 Civil Rights Coordinator*: or *Civil Rights Coordinator*: Means the responsible Providence caregiver(s) designated to coordinate Providence's efforts to comply with this policy in any Providence Health Program or Activity, including the investigation of any grievances filed under this policy, and who are listed by Region/Ministry in the Procedure section below.

Policy:

Consistent with Providence's Mission and Core Values, it is the policy of Providence to not discriminate against, exclude, or treat differently any individuals accessing any Providence Health Program or Activity on any basis prohibited by local, state or federal laws, including but not limited to on the basis of race, color, national origin, age, Disability, Handicap, or sex, as those terms are defined under federal law and rules. Where applicable, federal statutory protections for religious freedom and conscience are applied. It is also Providence's policy to provide free aids and language assistance services to individuals with a Disability, Handicap, or Limited English Proficiency who are accessing a Providence Health Programs or Activity. Such services may include providing Qualified Bilingual/Multilingual Staff, Qualified Interpreters, and Qualified Translators free of charge.

Providence has established an internal grievance procedure for individuals accessing any Providence Health Program or Activity, which provides for prompt and equitable resolution of complaints alleging violations of applicable federal or state laws that prohibit discrimination, including but not limited to Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (42 U.S.C. 18116), and its implementing regulations at 45 CFR part 92 (collectively referred to below as "Section 1557"). Any person who believes that someone accessing a Providence Health Program or Activity has been subjected to discrimination on the basis of race, color, national origin, sex, age, Handicap, or Disability may file a grievance under this procedure. It is against the law for Providence to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance. Providence maintains a non-retaliation policy at PROV-HR-419.

Section 1557 and its implementing regulations may be examined in the office of Providence's Vice President, Risk, Claims and Insurance, Valley Office Park - Southgate II, 1801 Lind Ave. SW, Renton, WA 98057, Tel: 1-844-469-1775 , Email: Nondiscrimination.PHS@providence.org who has been designated to coordinate Providence's System-level efforts to comply with Section 1557. Such information can also be obtained through each designated Section 1557 Civil Rights Coordinator (see contact information below).

Procedure:

List of Section 1557 Civil Rights Coordinators:

Region/Ministry	Civil Rights Coordinator	2 nd Level of Appeal
Alaska	Civil Rights Coordinator 3200 Providence Dr., Anchorage, AK 99508; Tel:1-844-469-1775; Email: Nondiscrimination.AK@providence.org	Vice President, Risk, Claims and Insurance – contact information above
California	Civil Rights Coordinator 501 S. Buena Vista St. Burbank, CA 91505 Tel:1-844-469-1775; Email: Nondiscrimination.CA@providence.org	Vice President, Risk, Claims and Insurance – contact information above
Montana	Civil Rights Coordinator 1801 Lind Avenue S.W., Renton, WA 98057; Tel:1-844-469-1775; Email: Nondiscrimination.MT@providence.org	Vice President, Risk, Claims and Insurance – contact information above
Oregon	Civil Rights Coordinator 5933 Win Sivers Dr., Suite 109, Portland, OR 97220 Tel:1-844-469-1775; Email: Nondiscrimination.OR@providence.org	Vice President, Risk, Claims and Insurance – contact information above
Washington	Civil Rights Coordinator 101 W. 8 th Avenue, Spokane, WA 99204 Tel:1-844-469-1775; Email: Nondiscrimination.WA@providence.org	Vice President, Risk, Claims and Insurance – contact information above
Providence Senior and Community Services	Civil Rights Coordinator 2811 S. 102nd St, Suite 220 Tukwila, WA 98168, Tel:1-844-469-1775; Email: Nondiscrimination.pscs@providence.org	Vice President, Risk, Claims and Insurance – contact information above

Individuals needing Telecommunications Relay Services to file a complaint, may call 1-800-833-6384 , or 7-1-1.

Investigation and Review Procedure:

- Any person who believes that someone accessing a Providence Health Program or Activity has been subjected to discrimination in violation of this policy may contact the above-noted Civil Rights Coordinator to discuss those concerns. Such persons may also file a complaint with Providence, as follows:
- Complaints must be submitted to the Civil Rights Coordinator (see above) within 60 days of the date the person filing the complaint becomes aware of the alleged discriminatory action.
- A complaint must be in writing, and must contain the name and address of the person making the complaint.

- The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Civil Rights Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested person(s) an opportunity to submit evidence relevant to the complaint. The Civil Rights Coordinator will maintain the files and records of Providence relating to such grievances. To the extent possible, and in accordance with applicable law, the Civil Rights Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Civil Rights Coordinator (or her/his designee) will issue a written decision on the complaint to the complainant, based on a preponderance of the evidence, no later than 30-45 days after the Civil Rights Coordinator's receipt of the complaint. The written decision will include notice to the complainant of their right to pursue further administrative or legal remedies.
- The complainant may appeal the decision of the Civil Rights Coordinator by writing to the Vice President, Risk, Claims and Insurance, or such other designee listed above, within 15 days of receiving the Civil Rights Coordinator's decision. A written decision shall be issued by the decision-maker at this second level of review no later than 30 days after his or her receipt of the appeal.

Providence Regions/Ministries may adopt their own nondiscrimination policies for Health Programs or Activities only to the extent that they are consistent with this System policy.

The availability and use of the foregoing complaint procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or Disability or Handicap in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> , or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201. Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>. Such complaints must be filed within 180 days of the date of the alleged discrimination. Providence will provide notices to the public regarding the foregoing appeal rights on Providence's website and in other significant publications.

Providence will make appropriate arrangements to ensure that individuals with Disabilities, Handicaps, and individuals with Limited English Proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing Qualified Interpreters, providing taped cassettes of material for individuals with low vision, or assuring an accessible location for the proceedings. The Civil Rights Coordinator, acting directly or through a designee, will be responsible for such arrangements, and dedicated phone lines will be provided to assist individuals in obtaining communication assistance services.

References:

- Section 1557 of the Affordable Care Act (42 U.S.C. 18116)
- Section 1557 implementing regulations at 45 CFR part 92
- Title VI of the Civil Rights Act of 1964
- Title IX of the Education Amendments of 1972
- The Age Discrimination Act of 1975, subject to the exclusions described in 45 CFR 91.3(b)(1)
- Section 504 of the Rehabilitation Act of 1973
- Cal. Health & Safety Code § 1259

For Providence's and Affiliates' Human Resources policies applicable to caregivers, or questions about

caregiver benefits, and applicable grievance procedures, see: Caregiver.eHR.com/Resources & Contacts/HR Policies.

For Providence Health Plan's policies applicable to nondiscrimination in the provision of health-related coverage and grievance procedures, see: <https://healthplans.providence.org/nondiscrimination-statement>.

- A. [^](#) For purposes of this policy, "Affiliates" is defined as any entity that is wholly owned or controlled by Providence Health & Services or Western HealthConnect (for example, Swedish Health Services, Swedish Edmonds, Kadlec Regional Medical Center, Saint John Medical Center, PacMed Clinics and Inland Northwest Health Services).
- B. [^](#) "Impairment" under Washington law includes, but is not limited to: (i) Any physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems; or (ii) Any mental, developmental, traumatic, or psychological disorder, including but not limited to cognitive limitation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.
- C. [^](#) For nondiscrimination and grievance policies related to Providence's provision of health-related insurance or other benefits, to Providence caregivers or through Providence Health Plan, please see the applicable links at the end of the References section below.

Attachments:

No Attachments

Approval Signatures

Approver	Date
Michele Herman: Program Mgr Leadership Svcs	04/2017
Becky Woo: Project Coordinator	04/2017
Martha Raymond: Vp Risk Claims And Insurance	04/2017

Applicability

AK - Providence Alaska MC & affiliates, AK - Providence Kodiak Island MC & affiliates, AK - Providence Seward MC & affiliates, AK - Providence Valdez MC & affiliates, CA - Providence Holy Cross MC, CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance, CA - Providence Saint John's Health Center, CA - Providence Saint Joseph MC, Burbank, CA - Providence Tarzana MC, MT - Providence St. Joseph MC, Polson, MT - St. Patrick Hospital, OR - Clinical Support Staff (CSS), OR - Connections, OR - Credena Health (CH), OR - Home Health (HH), OR - Home Medical Equipment (HME), OR - Home Services, OR - Home Services Pharmacy (HSRx), OR - Hospice (HO), OR - Providence Ctr for Medically Fragile Children, OR - Providence Hood River Memorial Hospital, OR - Providence Medford MC, OR - Providence Medical Group, OR - Providence Medical Group, OR - Providence Milwaukie Hospital, OR - Providence Newberg MC, OR - Providence Portland MC, OR - Providence Seaside Hospital, OR - Providence St. Vincent MC, OR - Providence Willamette Falls MC, Providence Health & Services, Providence Senior and Community Services, Swedish Medical Center - Ballard Campus, Swedish Medical Center - Cherry Hill Campus, Swedish Medical Center - Edmonds Campus, Swedish Medical Center - First Hill Campus, Swedish Medical Center - Issaquah Campus, WA - NWR Providence Medical Group, WA - Providence Centralia Hospital, WA - Providence Holy Family Hospital, WA - Providence Mount Carmel Hospital, WA - Providence Physician Services, WA - Providence Regional MC Everett, WA - Providence Sacred

COPY

Exhibit 18

Providence Regional Medical Center Everett Patient Origin Analysis

PRMCE Rehabilitation Unit Patient Origin by Discharges and Patient Days - CY2017

County	Discharges	% of Discharges	Patient Days	% of Days	County Total Patient Days (Regardless of Hospital)	PRMCE Market Share of County Total Days
Snohomish County	378	83.4%	3,764	82.1%	5,967	63.1%
Island County	34	7.5%	325	7.1%	621	52.3%
King County	13	2.9%	178	3.9%	15,731	1.1%
Skagit County	14	3.1%	132	2.9%	1,241	10.6%
Out-of-State	5	1.1%	77	1.7%	5,869	1.3%
Lewis County	2	0.4%	37	0.8%	691	5.4%
Kitsap County	2	0.4%	26	0.6%	1,723	1.5%
Clallam County	1	0.2%	19	0.4%	602	3.2%
Whatcom County	2	0.4%	15	0.3%	2,765	0.5%
Grays Harbor County	2	0.4%	14	0.3%	1,007	1.4%
Total	453	100.0%	4,587	100.0%		

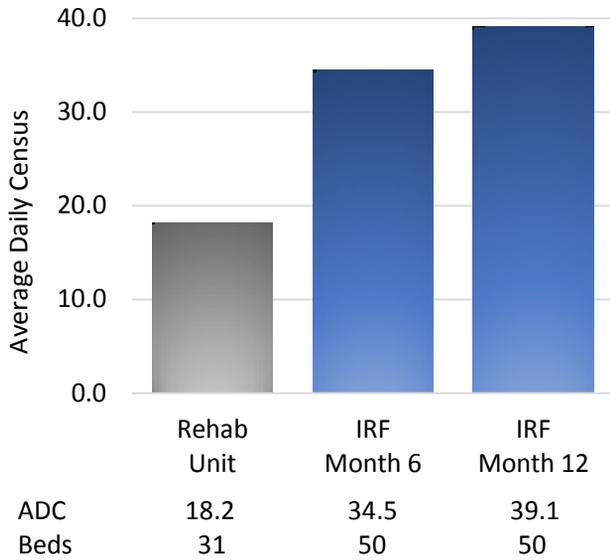
*Only rehabilitation-unit utilization is included in analysis

Source: CHARS 2017

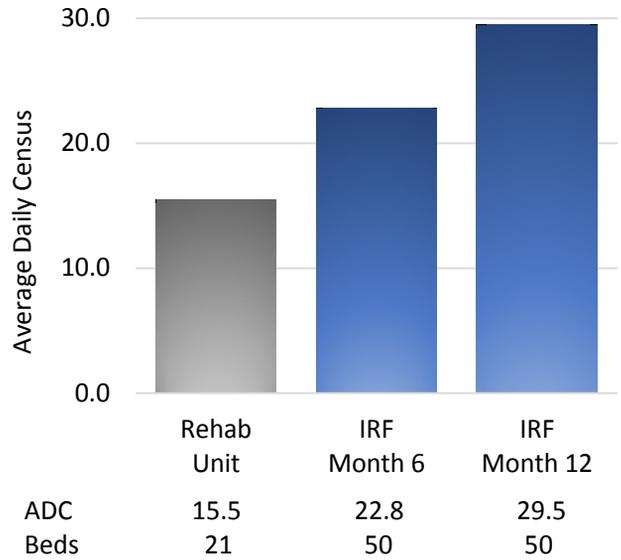
Exhibit 19

Kindred Rehabilitation Hospitals Utilization Growth Examples

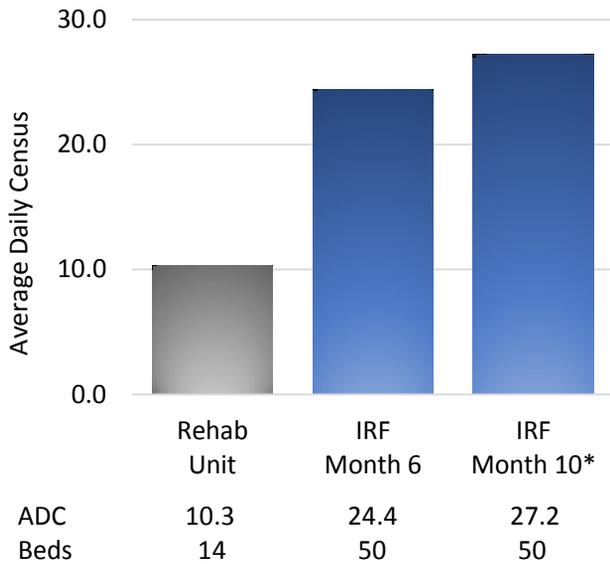
Northeast Rehab Hospital



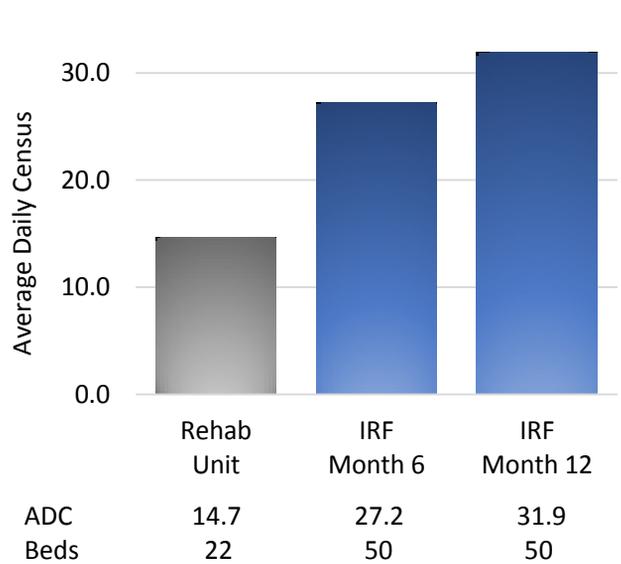
Great Lakes Rehab Hospital



Midwest Rehab Hospital



Average



* facility has only been open for 10 months



April 8, 2019

Janis Sigman, Manager
Certificate of Need Program
Washington State Department of Health
111 Israel Road SE
Olympia, WA 98504-7852

RE: Northwest Washington Rehabilitation Hospital, LLC Capital Commitment

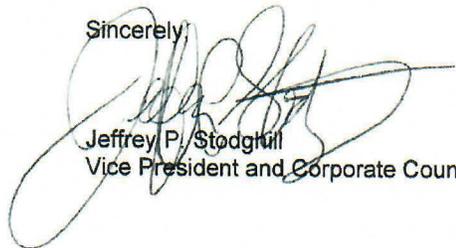
Dear Ms. Sigman:

Providence Health & Services ("Providence") and Kindred Healthcare, LLC. ("Kindred"), through their affiliates, intend to develop a free-standing inpatient rehabilitation facility (the "IRF") in Snohomish County, Washington through a joint venture (the "JV") between the two parties.

The purpose of this letter is to confirm to the Washington State Department of Health Certificate of Need Program that it is Kindred's intention to contribute to the capital of the JV (i) certain items of equipment suitable for use in the IRF's operations with a fair market value of Three Million Dollars (\$3,000,000) and (ii) cash in the amount of Four Million, Five Hundred Forty-Two Thousand, Seven Hundred Forty Dollars (\$4,542,740) to fund the JV's start-up costs and initial working capital requirements.

Please let me know if you need any additional information regarding this matter.

Sincerely,



Jeffrey P. Stodghill
Vice President and Corporate Counsel

Exhibit 20

Proforma Financials

HOSPITAL INFORMATION					
COMPARISON STATEMENT OF REVENUE & EXPENSE-UNRESTRICTED FUNDS					
	PROJECTED	PROJECTED	PROJECTED	PROJECTED	
	Jul-Dec 2021	2022	2023	2024	
1	OPERATING REVENUE:				
2	Inpatient Revenue	8,318,269	24,422,308	25,195,730	25,994,650
3	Outpatient Revenue	0	0	0	0
4	TOTAL PATIENT SERVICES REVENUE	8,318,269	24,422,308	25,195,730	25,994,650
6	DEDUCTIONS FROM REVENUE				
7	Provision for Bad Debt	(50,270)	(154,728)	(159,628)	(164,690)
8	Contractual Adjustments	(4,160,717)	(12,180,405)	(12,553,640)	(12,951,697)
9	Charity and Uncompensated Care	(128,448)	(376,141)	(388,053)	(400,358)
10	Other Adjustments and Allowances	0	0	0	0
11	TOTAL DEDUCTIONS FROM REVENUE	(4,339,436)	(12,711,275)	(13,101,321)	(13,516,745)
12	NET PATIENT SERVICE REVENUE	3,978,833	11,711,033	12,094,410	12,477,906
14	OTHER OPERATING REVENUE				
15	Other Operating Revenue	19,894	58,555	60,472	62,390
16	Tax Revenues	0	0	0	0
17	TOTAL OTHER OPERATING REVENUE	19,894	58,555	60,472	62,390
18	TOTAL OPERATING REVENUE	3,998,728	11,769,588	12,154,882	12,540,295
20	OPERATING EXPENSES				
21	Salaries and Wages	2,529,300	5,027,765	5,071,162	5,231,962
22	Employee Benefits	505,860	1,005,553	1,014,232	1,046,392
23	Management Fees	199,936	588,479	607,744	627,015
24	Medical Director Fee	49,400	98,800	98,800	98,800
25	Professional Fees	25,600	51,200	51,200	51,200
26	Supplies	318,459	367,808	379,456	391,488
27	Purchased Services - Utilities	86,208	178,735	179,645	180,585
28	Purchased Services - Other	121,043	310,338	320,166	330,318
29	Depreciation	214,286	428,905	431,619	438,000
30	Rentals and Leases	1,322,400	2,674,554	2,734,731	2,796,263
31	Insurance	44,398	103,964	106,148	108,404
32	License and Taxes	227,022	511,939	517,852	523,768
33	Interest	30,649	86,654	43,460	2,976
34	Other Direct Expenses	135,244	96,079	98,900	101,814
35	Allocated Expenses				
36	TOTAL OPERATING EXPENSES	5,809,805	11,530,772	11,655,117	11,928,984
37	NET OPERATING REVENUE	3,998,728	11,769,588	12,154,882	12,540,295
38					
39	NON-OPERATING REVENUE-NET OF EXPENSES	(1,811,077)	238,816	499,765	611,312
40					
41	NET REVENUE BEFORE ITEMS LISTED BELOW	3,998,728	11,769,588	12,154,882	12,540,295
42					
43	EXTRAORDINARY ITEM	0	0	0	0
44	FEDERAL INCOME TAX	0	0	0	0
46	NET REVENUE OR (EXPENSE)	3,998,728	11,769,588	12,154,882	12,540,295

HOSPITAL INFORMATION					
BALANCE SHEET - UNRESTRICTED FUND-HOSPITAL AGGREGATE					
ASSETS		PROJECTED	PROJECTED	PROJECTED	PROJECTED
		Jul-Dec 2021	2022	2023	2024
1	CURRENT ASSETS:				
2	Cash	401,098	401,135	406,159	416,272
3	Marketable Securities	0	0	0	0
4	Accounts Receivable	1,888,221	1,891,326	1,951,222	2,007,592
5	Less-Estimated Uncollectable & Allowances	0	0	0	0
6	Receivables From Third Party Payors	0	0	0	0
7	Pledges And Other Receivables	0	0	0	0
8	Due From Restricted Funds	0	0	0	0
9	Inventory	44,091	44,091	44,091	44,091
10	Prepaid Expenses	0	0	0	0
11	Current Portion Of Funds Held In Trust	0	0	0	0
12	TOTAL CURRENT ASSETS	2,333,411	2,336,552	2,401,472	2,467,955
13					
14	BOARD DESIGNATED ASSETS:				
15	Cash	0	0	0	0
16	Marketable Securities	0	0	0	0
17	Other Assets	0	0	0	0
18	TOTAL BOARD DESIGNATED ASSETS	0	0	0	0
19					
20	PROPERTY, PLANT AND EQUIPMENT:				
21	Land	0	0	0	0
22	Land Improvements	0	0	0	0
23	Buildings	0	0	0	0
24	Fixed Equipment - Building Service	0	0	0	0
25	Fixed Equipment - Other	0	0	0	0
26	Equipment	3,000,000	3,008,000	3,040,000	3,088,000
27	Leasehold Improvements	0	0	0	0
28	Construction In Progress	0	0	0	0
29	TOTAL	3,000,000	3,008,000	3,040,000	3,088,000
30	Less Accumulated Depreciation	(214,286)	(643,190)	(1,074,810)	(1,512,810)
31	NET PROPERTY, PLANT & EQUIPMENT	2,785,714	2,364,810	1,965,190	1,575,190
32					
33	INVESTMENTS AND OTHER ASSETS:				
34	Investments In Property, Plant & Equipment	0	0	0	0
35	Less - Accumulated Depreciation	0	0	0	0
36	Other Investments	0	0	0	0
37	Other Assets	0	0	0	0
38	TOTAL INVESTMENTS & OTHER ASSETS	0	0	0	0
39					
40	INTANGIBLES ASSETS:				
41	Goodwill	0	0	0	0
42	Unamortized Loan Costs	0	0	0	0
43	Preopening And Other Organization Costs	0	0	0	0
44	Other Intangible Assets	4,636,765	4,636,765	4,636,765	4,636,765
45	TOTAL INTANGIBLE ASSETS	4,636,765	4,636,765	4,636,765	4,636,765
46	TOTAL ASSETS	9,755,890	9,338,126	9,003,427	8,679,910

HOSPITAL INFORMATION					
BALANCE SHEET - UNRESTRICTED FUND-HOSPITAL AGGREGATE					
LIABILITIES AND FUND BALANCES-UNRESTRICTED	PROJECTED Jul-Dec 2021	PROJECTED 2022	PROJECTED 2023	PROJECTED 2024	
1	CURRENT LIABILITIES:				
2	Notes and Loans Payable	0	0	0	0
3	Accounts Payable	401,098	401,135	406,159	416,272
4	Accrued Compensation and Related Liabilities	0	0	0	0
5	Other Accrued Expenses	0	0	0	0
6	Advances from Third Party Payors	0	0	0	0
7	Payables to Third Party Payors	0	0	0	0
8	Due to Restricted Funds	0	0	0	0
9	Income Taxes Payable	0	0	0	0
10	Other Current Liabilities	0	0	0	0
11	Current Maturities of Long Term Debt	1,754,104	1,097,488	258,000	0
12	TOTAL CURRENT LIABILITIES	2,155,202	1,498,622	664,159	416,272
14	DEFERRED CREDITS:				
15	Deferred Income Taxes	0	0	0	0
16	Deferred Third Party Revenue	0	0	0	0
17	Other Deferred Credits	0	0	0	0
18	TOTAL DEFERRED CREDITS	0	0	0	0
19					
20	LONG TERM DEBT:				
21	Mortgage Payable	0	0	0	0
22	Construction Loans - Interim Financing	0	0	0	0
23	Notes Payable	0	0	0	0
24	Capitalized Lease Obligations	0	0	0	0
25	Bonds Payable	0	0	0	0
26	Notes and Loans Payable to Parent	0	0	0	0
27	Noncurrent Liabilities	0	0	0	0
28	TOTAL	0	0	0	0
29	Less Current Maturities of Long Term Debt	0	0	0	0
30	TOTAL LONG TERM DEBT	0	0	0	0
31					
32	UNRESTRICTED FUND BALANCE	0	0	0	0
33					
34	EQUITY (INVESTOR OWNED)				
35	Preferred Stock	0	0	0	0
37	Common Stock	1,000	1,000	1,000	1,000
39	Additional Paid In Capital	9,410,765	9,410,765	9,410,765	8,723,823
41	Retained Earnings				
42	Beginning Balance	0	(1,811,077)	(1,572,261)	(1,072,496)
43	Plus: Net Income	(1,811,077)	238,816	499,765	611,312
44	Less: Distributions / Dividends	0	0	0	0
45	Equals: Ending Balance	(1,811,077)	(1,572,261)	(1,072,496)	(461,185)
47	Less Treasury Stock	0	0	0	0
48	TOTAL EQUITY	7,600,688	7,839,504	8,339,269	8,263,638
49	TOTAL LIABILITIES AND FUND BALANCE OR EQUITY	9,755,890	9,338,126	9,003,427	8,679,910

Financial Proforma Assumptions

Line Item	Assumption
Revenue	
Inpatient Revenue	The revenue is based on the payer mix and utilization projections detailed in earlier sections of this application. Charges and reimbursement calculations were based on the experience of PRMCE operating its acute rehabilitation service. There is no revenue inflation assumed.
Other Operating revenue	Revenue from Dining services, vending machines, etc.
Deductions From Revenue	
Provision for Bad Debt	2.5% of non-Medicare revenue
Charity Care	1.54% of gross revenue, 3.21% of adjusted revenue
Contractual Allowances	Details provided below
Operating Expenses	
Salaries, Wages and Employee Benefits	Staffing detail by FTE is provided in Exhibit 18. Salaries are based on PRMCE current rates and benefits are assumed to be 20% of salaries.
Management Fees	5% of net revenues paid to manager for cost incurred to manage and operate daily activities of JV facility
Medical Director Fee	Based on 10hr per week at \$190 per hour
Supplies	\$64 per patient day in year 3, based on Kindred historical experience with similar sized facilities
Purchased Services - Utilities	\$30.30 per patient day in year 3, based on Kindred historical experience with similar sized facilities
Purchased Services - Other	\$54.01 per patient day in year 3, based on Kindred historical experience with similar sized facilities
Depreciation	Depreciation is based on straight line method and is for the equipment only and assumes 7 years for useful life
Rentals and Leases	\$32.0M Building and \$2.8M land cost leased to NWRH at 7.6% market cap rate
Insurance	\$17.90 per patient day in year 3, based on Kindred historical experience with similar sized facilities
Interest	Interest expense based on a 6% rate for Kindred-provided working capital funding based on operational cash flow needs
Other Direct Expenses	\$16.68 per patient day in year 3, based on Kindred historical experience with similar sized facilities
Balance Sheet Items	
Intangible Assets	\$4.6mm of intangible assets relates to the imputed accounting value of Providence's contribution of the 19-bed ARU at PRMCE to the JV partnership in exchange for a 49% ownership stake of total partnership assets at JV formation.

Contractual Allowances

	Contractual Allowances by Payor			
	2021	2022	2023	2024
Medicare PPS	-51.0%	-50.9%	-50.8%	-50.8%
Medicare HMO	-55.8%	-55.8%	-55.8%	-55.8%
Managed Care / Commercial	-41.8%	-41.8%	-41.8%	-41.8%
Medicaid	-75.3%	-75.3%	-75.3%	-75.3%
Total	-51.6%	-51.4%	-51.4%	-51.4%

Exhibit 21

Staffing Schedule

Northwest Washington Rehabilitation Hospital
Staffing Schedule

Position	FTE Count			
	H2 2021	2022	2023	2024
Director of Nursing	1.0	1.0	1.0	1.0
Dir CQPI	1.0	1.0	1.0	1.0
Nurse Manager	1.0	1.0	1.0	1.0
Nurse Coordinator(PPS)	1.0	1.0	1.0	1.0
Director of Therapy	1.0	1.0	1.0	1.0
CEO	1.0	1.0	1.0	1.0
Controller	1.0	1.0	1.0	1.0
HR Director	1.0	1.0	1.0	1.0
Marketing/Business Development	4.0	4.0	4.0	4.0
RNs	10.2	12.5	13.3	13.3
LPNs	4.4	5.3	5.7	5.7
CNA/MA	9.7	11.9	12.7	12.7
Physical Therapists	2.0	2.0	2.0	2.0
Physical Therapy Assistant (PTA)	0.4	1.0	1.2	1.2
Physical Therapy Techs	0.5	1.0	1.0	1.0
Occupational Therapists	2.0	2.0	2.0	2.0
Occupational Therapy Assistant (COTA)	0.4	1.0	1.2	1.2
Occupational Therapy Techs	0.5	1.0	1.0	1.0
Speech Language Pathologist (SLP)	2.0	2.0	2.0	2.0
Respiratory Therapists	1.1	1.1	1.1	1.1
Pharmacists	1.0	1.0	1.4	1.4
Pharmacy Techs	1.0	1.0	1.0	1.0
Case Manager/Social Worker	1.5	1.5	1.5	1.5
Central Supply/Purchasing	1.0	1.0	1.0	1.0
Dietary Supervisor	1.0	1.0	1.0	1.0
Registered Dietitians	0.5	1.0	1.0	1.0
Cooks	2.5	2.5	2.5	2.5
Dietary Aides	2.5	2.5	2.5	2.5
Dietary Clerks	0.5	0.5	1.0	1.0
Maintenance Supervisor	1.0	1.0	1.0	1.0
Housekeeping Supervisor	1.0	1.0	1.0	1.0
Housekeepers	2.0	3.0	3.0	3.0
Switchboard Operators	2.1	2.1	2.1	2.1
Accounting	1.0	1.0	1.0	1.0
Business Office	2.0	2.0	2.0	2.0
Medical Records	1.5	1.5	1.5	1.5
Admin Secretary	1.0	1.0	1.0	1.0
Unit Secretary	2.8	2.8	2.8	2.8
Total	71.0	80.2	83.4	83.4

H2 2021 full-time equivalent employees shown will be employed for half of the 2021 opening year; financial statements reflect salaries, wages and benefits for this partial period.

Exhibit 22

Providence Regional Medical Center Everett Transition Planning Referral Policy



Implementation:	10/2000
Effective:	08/2017
Last Reviewed:	08/2017
Last Revised:	08/2017
Next Review:	08/2020
Owner:	<i>Kristen Jacobson: Manager</i>
Policy Area:	<i>Case Management/Care Management</i>
References:	
Applicability:	<i>WA - Providence Regional MC Everett</i>

Transition Planning Referrals

Scope

Care Management (clinical social workers, mental health professionals and RN care managers), Nursing, LIP, clinicians.

Purpose:

To define the multidisciplinary process for the development of a transition plan responsive to both the clinical and social needs of the patient, family and caregivers involved in care of the patient.

Care Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the patients' health and human service's needs. Care management is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.

Care Managers shall assist patients and families in obtaining appropriate post-hospital level of care while assuring continuity of care and safe discharge planning to the community. The Care Management Department has an open referral policy. Referrals will be accepted for care managers from physicians, hospital personnel, community agencies, the patient, family or friends.

This policy applies to adult units as charting guidelines and expectations will be different for the patients in the Labor and Delivery, Pediatrics and the Neonatal Intensive Care Unit. Those guidelines are covered in another policy.

Definitions

None

Prerequisite Information:

Disciplines responsible for evaluation of patient post discharge needs include, but are not limited to, medical staff services, nursing services, case management, licensed therapists, pharmacists, and dietitians.

All employees are required to alert nursing, medical staff or case management of discharge concerns.

Nursing and medical staff refer discharge/transition concerns to the Care Management Department, Social

workers or case managers via electronic medical record (EMR) order entry.

Care Management department identifies, either via referral or during initial screening, patients who require or may benefit from discharge planning intervention.

Other departments refer concerns via 1:1 communication with care management staff or through Unit-based interdisciplinary rounds.

Multidisciplinary team members document to the plan of care professional concerns and treatment plans, including anticipated patient discharge needs.

Nursing, LIPs, and the care management staff may assess patients using the High Risk Discharge Screening Tool (Lace Tool) to augment their clinical knowledge base.

Policy:

Screening

1. All hospital bedded patients are screened for discharge needs by admitting RN. The admission screening tool include the following "discharge need" screening questions:
 - Are there any anticipated Changes Related to Illness?
 - Are there any anticipated services need at Discharge?
 - What is your anticipated Discharge Disposition?
 - Role relationships, family and support assistance?
 - Living Environment/Living Arrangements?
 - Disability Screen which includes hearing/vision/stairs/dressing changes.
 - Do you have a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?
 - Do you have serious difficulty dressing or bathing?
 - Do you have difficulty doing errands alone due to a physical, mental or emotional condition?
 - Abuse Screen.
 - Current Functional Status and Prior Functional Status.
2. The High Risk Discharge Screening Tool (Lace Tool) may also be used but clinical judgment determines need for further evaluation.
3. RN refers all patients who may have discharge needs to unit Care Management staff via CM/SW referral process.
4. RN may determine that the standard After Visit Summary (AVS), discharge education, and home care environment needs can be addressed with the usual multidisciplinary team process without Care Management involvement.
5. LIP, physical therapist, occupational therapist, speech language pathologist, pharmacist, and nutritional services include Care Manager Assessment and evaluation in their initial assessment. Any concerns are documented and referred to Care Management for evaluation or discharge planning.
6. Patient, family and caregivers are included in discussion of discharge concerns and needs whenever possible and appropriate.

7. Each patient has the opportunity to formally request Care Management assistance in discharge planning.
8. Care Management uses direct referral, patient rounding/unit rounding, ongoing chart review, and patient communication to identify patients who may need discharge planning assistance, regardless of initial assessment.

Evaluation

1. The Nurse Care Manager or Clinical Social Worker/Mental Health Professional evaluates the current and anticipated clinical condition and current and anticipated living arrangements on all patients early in the stay.
2. All departments may identify anticipated caregiver(s) and document the name(s) and contact information. New information, including contact information, is added to the chart.
3. The Nurse Care Manager and/or Clinical Social Worker/Mental Health Professional communicate with the anticipated caregiver to ensure that he/she is willing and able to meet caregiving demands.
4. Short stay admissions may require that nursing and/or LIP team members assess the care giving needs of the patient and caregiver's abilities. In cases where serious concern arises, a referral for Care Management is ordered, or in situations anticipated to be unsafe, the discharge is postponed until a Care manager assessment is completed.
5. For any concerns regarding abuse or neglect of a vulnerable adult or child, see [Abuse and Neglect, Identifying and Reporting](#).

Development

1. Nurse Care Managers and Clinical Social Workers/ Mental Health Professionals collaborate to develop coordinated discharge plans using the evaluations and assessments of the interdisciplinary team along with the goals of the patient, family and caregiver.
2. The Care Management team uses community resources and alternative discharge environments. In addition, caregivers' abilities to meet patient needs are supported by providing education or counseling opportunities as needed.
3. All clinicians work with the patient and designated caregivers, who are encouraged to be involved in all aspects of developing and executing the discharge plan.
4. The assessment for and development of the discharge plan begins at or before admission and is on-going throughout the hospital stay.
5. Care Management documents the assessment and discharge plan in the electronic medical record (EMR) and utilizes Care Management software for referrals to community partners.
6. The discharge plan is fluid until time of discharge.
7. PRMCE refers to facilities or providers designated to provide an appropriate level of care. PRMCE considers a facility's acceptance of a patient as proof that the facility is able to meet the needs of the patient they are accepting.

Initiation

1. The interdisciplinary team communicates with patient/family/caregiver as early as possible regarding a potential discharge date. See Important Message from Medicare job aide process.

2. LIP writes appropriate discharge order including reconciliation of discharge medication as well as prescription(s) for new medication(s). The LIP may order durable medical equipment, oxygen and other discharge supplies as needed.
3. Patients without insurance are evaluated for the PRMCE charity medication program and other charity programs to assist in meeting discharge needs.
4. The Nurse Care Manager or Clinical Social Worker/ Mental Health Professional annotates all aspects of the discharge plan including any arranged LIP visits, home health, community referrals, and special instructions in the EMR.
5. Care Managers/direct care nurses/Transition Associates update the AVS to include any known upcoming appointments, treatments or tests that are planned for near future.
6. Care Management facilitates the transfer to post-acute environment. This includes assurance that necessary medical records are transferred to accepting facility.
7. Discharge Summary: A copy is printed by direct care nurse and sent with patient to provide to his/her PCP.
8. Multidisciplinary team members may arrange or educate patient/caregiver how to procure necessary equipment or supplies for discharge.

Compliance

1. A skilled nursing facility (SNF) or home health/hospice (HH/H) Freedom of Choice list is given to any patient potentially discharging to a SNF or with HH/H, whether already residing in or receiving this service.
2. The discharge plan that the patient, family, or caregiver desires or demands may be deemed less safe than what is possible to obtain, but the rights of the patient to determine his/her own needs outweigh the hospital's concerns as long as the patient is competent to make decisions and the patient/family/caregivers acknowledge associated safety risks.

Regulatory Requirements

Centers for Medicare & Medicaid Services (CMS). 42 CFR 482.43 – Condition of Participation: Discharge Planning.

Det Norske Veritas (DNV). Discharge Planning.

The Joint Commission (TJC). PC.04.01.01, PC.04.01.03, RC.02.01.01.

DOH. WAC 246-320-226 – Patient Care Services.

RCW 7.70.065 – Informed Consent.

References

Swedish Policy, 2015

LINK TO JOB AIDES:

<https://wamtteams.providence.org/sites/nwr/tp/Standard%20Work%20-%20Job%20Aides/Forms/AllItems.aspx>

Addenda

High Risk Discharge Screening Tool (No high risk screening tool can completely cover allPotential concerns in any patient population. The tool is designed to aid staff to determine types of issues which may be appropriate for further in-depth assessment and intervention.)

Author/Contact

Katherine McFarland RN, MN, Director, Care Management

Co-Authors

Kristen E. Jacobson LICSW, Manager, Care Management

Attachments:

No Attachments

Approval Signatures

Approver	Date
James Cook: Chief Medical Officer	08/2017
Kristen Jacobson: Manager	08/2017

Applicability

WA - Providence Regional MC Everett

COPY

Appendix 1

Audited Financials

Providence Health & Services – 2015

Providence St. Joseph Health – 2016, 2017

Management's Discussion and Analysis of Financial Condition and Results of Operations

Year ended December 31, 2015

Todd Hofheins, Executive Vice President and Chief Financial Officer



The care and services Providence delivers spans from birth to hospice, to care for the whole person. Our comprehensive scope of services includes acute care, physician clinics, long term and assisted living, palliative and hospice care, home health, education and supportive housing. Our ministries are in Alaska, California, Montana, Oregon and Washington with our system office located in Renton, Washington.



Introduction to Management's Discussion and Analysis

Management's discussion and analysis provides additional narrative explanation of the financial condition, operational results and cash flow of Providence Health & Services (Providence) to increase understanding of the health system's combined financial statements. The discussion and analysis should be read in conjunction with the accompanying audited combined financial statements.

Creating healthier communities, together

As health care evolves, Providence is responding with a vision and core strategy to transform and innovate at scale. Across five states, Providence and its affiliates continue to pioneer how care is delivered by sharing one strategic plan designed to improve the health of entire populations by supporting the well-being of each person we serve. Our core strategy of "*Creating healthier communities, together*" is supported by five specific areas of focus in our strategic plan:

- Inspire: We must first inspire and develop our people.
- Know: To serve our communities effectively, we are building enduring relationships with consumers.
- Partner: Providing the best care requires new alignments with clinicians and care teams.
- Adapt: We'll develop and thrive under new care delivery and economic models.
- Adopt: To serve more people we will grow by optimizing expert-to-expert capabilities.

This plan supports our vision, "Together, we answer the call of every person we serve: Know me, care for me, ease my way ®," which is our promise to our patients, customers and communities. Through innovation, excellence, good stewardship and working together across Providence, we will continue to lead change to improve the health of our communities.

Investing in our communities to improve health and increase access

With strong support from Providence, Alaska launched Medicaid expansion in 2015 and Montana began expansion early in 2016, ensuring that all five of our states have increased eligibility under the Affordable Care Act. In an environment of decreased reimbursement for government-sponsored medical care, community benefit spending related to the unpaid costs of Medicaid was \$538 million in 2015 compared with \$444 million in 2014. Providence cares for everyone, regardless of their ability to pay. In 2015 we provided more than \$951 million in community benefit, which increased over \$100 million from 2014.

Providence had a strong impact on landmark new payment codes that recognize the value of advance care planning by reimbursing clinicians for having these discussions with their patients. The Centers for Medicare and Medicaid Services adopted recommendations developed by Providence and our partners that advance care planning be added as an optional, separately billable, element of the annual wellness visit. Going into effect in 2016, these codes will be instrumental for Providence, other Catholic ministries, and other providers that are committed to whole-person care models.

Together, we answer the call of every person we serve: Know me, care for me, ease my way.

Collaborating with like-minded partners

St. Joseph Health System

Providence and St. Joseph Health continue to work through the process of bringing our organizations together after signing a letter of intent in July 2015 and a definitive agreement in November 2015 to create a new single organization. Closure of the transaction is dependent on the timing of regulatory review, which we now estimate will be complete in the second quarter of 2016.

The two Catholic health systems, with long histories of serving communities in the American West, plan to create a new parent organization, Providence St. Joseph Health, that will focus on a shared mission and vision, as well as the strategic, financial and operational direction for the system overall. Dr. Rod Hochman will serve as the CEO of the parent organization, which will be based in Renton, Wash. There will be two system offices - in Renton and in Irvine, Calif. The board of directors of the parent organization will include seven members appointed by Providence and seven members appointed by St. Joseph Health.

“Together, we can invest more in the needs of everyone we serve, especially the most vulnerable.”
-Rod Hochman, M.D.,
President and CEO

Walgreens

As part of our commitment to creating healthier communities together, Providence is collaborating with Walgreens to open 25 clinics in Walgreens stores in Oregon and Washington during the next two years, starting with six clinics in Portland and Seattle opening in February 2016. In Portland, the clinics will be operated by Providence, staffed by Providence providers, and called Providence Express Care at Walgreens and in the Seattle area will be operated by Swedish, staffed by Swedish providers, and called Swedish Express Care at Walgreens. This program is another way we are answering the call of every person we serve. Current patients will experience a seamless patient experience through our existing electronic health record system, providing direct connectivity to the clinics and billing systems which will ensure better continuity of patient care and collaboration among providers.

Greater Fairbanks Community Hospital Foundation

Providence has signed a letter of intent with the Greater Fairbanks Community Hospital Foundation to pursue a lease agreement under the secular entity Western HealthConnect. The agreement would cover operations for Fairbanks Memorial Hospital, Denali Center and Tanana Valley Clinic. Fairbanks Memorial Hospital has 152 licensed beds and has served the community for more than 40 years.

The Hospital Foundation began a search for a new lease agreement partner after deciding not to renew a 15-year affiliation with Arizona-based Banner Health. Providence is honored to be selected as their proposed new partner and look forward to working with the Hospital Foundation to create healthier communities, together. We are excited to continue this tradition and to return to the Fairbanks community, where we served from 1910 to 1968.

As part of the letter of intent, we will negotiate a transition lease - under essentially the same terms as Banner - with the intent to negotiate a multi-year lease in the future. The lease agreement will be with Western HealthConnect, the entity formed to allow Providence to remain Catholic and secular affiliates to

remain secular. This is the same model we used for our affiliations with Swedish, Pacific Medical Centers and Kadlec.

Leading dynamic change through innovation

Population Health

Population health will be a critical part of achieving Providence's strategy of creating healthier communities, together. Our goal is to maximize the health outcomes of the people in our defined populations and communities through the design, delivery and coordination of affordable quality health care. We are focused on the customer experience, while driving operational and financial excellence through our innovation in this space.

Consumer Health Engagement and Support

Our innovation team is developing tools and services that engage consumers to keep them healthy between episodes of care. For example, we will test a new service line for our 65 and over population that aims to increase the options seniors have in the choice to safely age in place in their homes and defer the stress and costs of a move to a long term care facility. The program will partner with our clinics to support day to day living tasks like meal delivery and transportation, improve the safety of a senior's home, and provide trusted planning and advice about aging optimally.

Providence ExpressCare

In order to provide health care to our patients on their own terms through a diverse range of care delivery offerings, Providence has launched ExpressCare, where patients can receive primary care in a retail setting. In addition to twenty-five ExpressCare Walgreens-embedded clinics, twenty-five standalone retail clinics will be opening throughout Washington, Oregon, California, and Montana in 2016 and 2017. ExpressCare clinics will be equipped with in-clinic "Appointments Now Available" monitors, website registration and scheduling, as well as walk-in kiosks with scheduling, check-in, and registration. ExpressCare will also be supported by a mobile app with clinic search, scheduling, registration and MyChart access as well as integrated telehealth.

Telehealth

Significant progress was made on our 2015 priorities including: iterating on and rolling out a new B2B technical infrastructure, turning on self-service features, accelerating deployment velocity and efficiency, and developing capabilities to be able to deploy easily to new service lines. We have developed a fully integrated platform that will effectively support both expert-to-expert telehealth as well as direct to consumer telehealth. Priorities for 2015 included improving quality of communication for clinicians and

Leadership in the Healthcare Industry

Rod Hochman, M.D., president and chief executive officer, was recently appointed to the Board of Trustees for the Catholic Health Association of America.

Mike Butler, president, operations and services, has joined the Board of Directors of Medical Teams International.

Amy Compton-Phillips, M.D., executive vice president and chief clinical officer, along with **Rhonda Medows, M.D.**, executive vice president of population health, were recently listed in Becker's Hospital Review annual list of influential female leaders in health care.

patients, reduced cost and accelerated deployment, safe and easy self-service features, and developing capabilities to be able to deploy easily to new service lines. The expert-to-expert telehealth platform for Telestroke was launched in 43 locations, while the Telehospitalist program completed a successful pilot and is now being deployed more broadly. HealthExpress, our \$39 urgent care telehealth offering is now available in Washington and Oregon. Visit <http://healthexpress.com> to learn more.

Providence Milestones

- Named as one of the 'Most Wired' organizations in health care by the American Hospital Association.
- Ranked 153 of 500 on the Forbes list of America's Best Employers in 2015.
- The power of our Mission continues to shine through in a recent survey with 92 percent of caregivers (all employees) agreeing with the statement, "My work supports the Mission."

Financial Performance

Year-end Results

Key Financial Indicators	2015	2014	Organic Growth*
<i>Data is year-to-date; dollar figures presented in millions</i>			
Net Operating Income	\$262	\$219	\$233
Net Income	\$77	\$771	\$44
EBIDA	\$864	\$1,133	\$807
Total Community Benefit	\$951	\$848	\$931
Operating Margin %	1.8%	1.8%	1.7%
Accounts Receivable Days	47	50	48
Days of Cash on Hand	159	183	163
Long-term Debt to Total Capitalization	33.8%	33.8%	33.3%
Cash to Debt	138.1%	130.9%	148.2%

** Reflects 2015 year-to-date results from entities that have been affiliated with Providence for more than 12 months.*

Operating income increased by 19.5 percent over the prior year, growing from \$219 million in 2014 to \$262 million in 2015. Operating margin remained consistent with the prior year at 1.8 percent while revenues continued to increase in 2015. Total net service revenue grew 16.7 percent or \$1.7 billion over the prior year from \$10.1 billion in 2014 to \$11.8 billion in 2015 driven by higher volumes and the recognition of revenue from state provider tax programs.

While operating income experienced positive growth in 2015, annual investment performance had a negative impact on Providence's net income and earnings before interest, depreciation, amortization and affiliation gains (EBIDA) as a result of challenging market conditions. Total investment losses for the year were \$114 million as compared to \$178 million in positive investment income in 2014. As a result, net income for the twelve months ended December 31, 2015 was \$77 million as compared to \$771 million in the prior year. Net non-operating income, excluding investment income, was -\$71 million in 2015 compared to \$374 million in 2014. The 2015 non-operating income was primarily impacted by pension settlement costs, while 2014 was benefited from affiliation related gains, partially offset by extinguishment of debt and pension settlement costs. EBIDA was \$864 million in 2015 as compared to \$1,133 million in 2014.

Several of the states we serve operate broad-based provider tax programs to fund the non-federal share of Medicaid. Providence recorded net operating income of \$84 million during the twelve months of 2015 related to these programs, compared to no related revenue in the prior year. Timing of program approval by regulating agencies can impact the timing of recognizing related income, and as a result, approximately \$50 million of the provider tax income recorded in 2015 related to services provided in 2014.

Liquidity & Capital

Unrestricted cash reserves totaled \$5.8 billion as of December 31, 2015 compared to \$6.0 billion as of December 31, 2014. The decrease was primarily driven by investment losses, capital purchases, and debt payments made during the year, partially offset by cash generated from operations.

Days cash on hand (DCOH) decreased 24 days from 183 days on December 31, 2014 to 159 days on December 31, 2015. This decline was driven by a combination of factors. First, a reduction in cash reserves primarily driven by investment losses. Second, patient volume growth led to higher operating revenues and corresponding expenses year over year.

Volumes

Key Volume Indicators	2015	2014	Organic Growth*
<i>Data is year-to-date; presented in thousands unless noted</i>			
Inpatient Admissions	362	333	353
Acute Adjusted Admissions	651	602	633
Total Emergency Room Visits	1,457	1,332	1,411
Total Surgeries	244	227	238
Continuum Services Visits	2,319	2,272	2,319
Physician Care Visits	7,742	6,881	7,443
Connected Lives - Member Months	6,050	5,147	6,050
Observations	56	58	56
Rate - Net Service Revenue/CMAA (whole value)	\$12,295	\$11,499	\$12,299
CMI Adjusted Length of Stay (whole value)	2.9	2.9	2.9

** Reflects 2015 year-to-date results from entities that have been affiliated with Providence for more than 12 months.*

Providence's continued investment in our communities and strategy of collaborating with like-minded partners led to higher acute setting volumes in 2015. Year-to-date inpatient admissions of 362 thousand were 29 thousand or 8.7 percent higher than the prior year. Year-to-date surgeries of 244 thousand were 17 thousand higher than prior year, which represented a 7.3 percent increase. Surgery counts increased in both inpatient and outpatient categories with inpatient increasing 8.7 percent and outpatient increasing 6.1 percent in 2015 as compared to 2014. Emergency visits were 125 thousand visits or 9.4 percent higher in 2015.

Strategic focus and innovations in clinical and home based care led to growth in these categories in 2015. Physician visits of 7,742 thousand were 861 thousand visits higher than the prior year, an increase of 12.5

percent. Continuum services, which include long term care, hospice, housing, assisted living and home health, generated 2,319 thousand visits year-to-date, which was 2.1 percent higher than the prior year.

The Providence Health Plan has continued to expand its services in the changing coverage landscape. Connected lives member months, a measure of coverage for insured members, increased from 5,147 member months in 2014 to 6,050 member months in 2015. This growth in member coverage represented a 17.5 percent increase compared to the prior year. Enrolled members, including Administrative Services Only (ASO) members, grew 17 percent from 437 thousand in December 2014 to 513 thousand in December 2015.

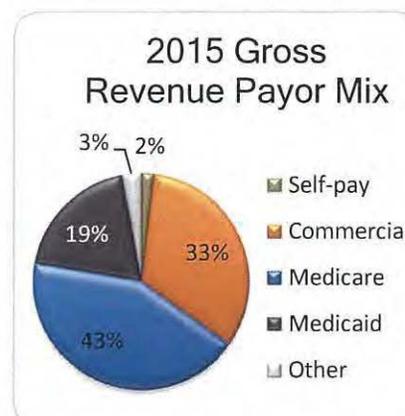
Revenue

Operating Revenue	2015	2014	Organic Growth*
<i>Data is year-to-date; figures presented in millions</i>			
IP Net Service Revenue	\$ 6,386	5,306	6,235
OP Net Service Revenue	3,381	3,145	3,252
Primary Care	1,486	1,232	1,465
Continuum Services	715	612	715
Capitated & Premium Revenue	1,862	1,683	1,814
Bad Debt	(186)	(193)	(179)
Other Revenue	790	696	781
Total Operating Revenue	\$ 14,434	12,481	14,083

** Reflects 2015 year-to-date results from entities that have been affiliated with Providence for more than 12 months.*

Year-to-date operating revenue of \$14.4 billion was \$2.0 billion or 15.6 percent greater than prior year. Revenue included \$612 million from provider tax related programs, of which \$240 million was related to the prior year. Payments related to 2014 were recorded in 2015 due to the timing of program approvals from state agencies that administer the provider fee programs. Capitated revenue of \$399 million was 17.6 percent higher than the prior year as a result of growth in our accountable care organizations. Total premium revenue of \$1,464 million was 8.9 percent higher as membership in the Providence Health Plans expanded in 2015. Premium revenue grew at a slower rate than enrollments primarily due to a change in product mix from 2014 to 2015, which saw a general shift towards more high deductible plans. Capitated and premium revenue represented 13 percent of Providence's total operating revenue, in line with the prior year.

Since 2012 Providence has participated in federal programs designed to provide incentive funding to hospitals and providers that implement electronic health record systems. Providence recorded \$22 million in revenue in 2015 related to this meaningful use funding, which was lower than the \$55 million recorded in 2014. This year-over-year decrease was expected as most providers and hospitals near the end of the three year incentive program.



Operating Expenses

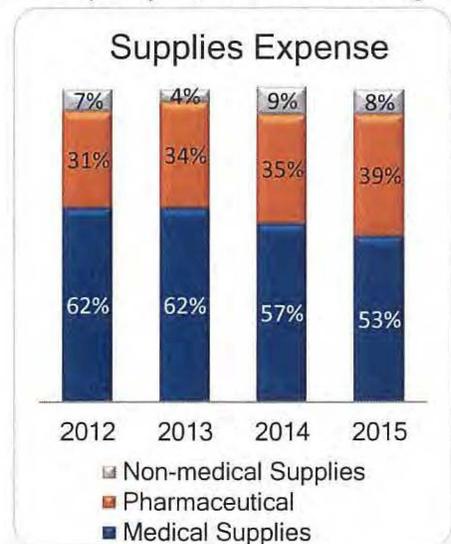
Key Efficiency Indicators	2015	2014	Organic Growth*
<i>Data is year-to-date</i>			
FTEs (presented in thousands)	70.4	65.4	67.1
Productivity - Labor % Net Service Rev.	50.8%	52.0%	50.9%
Supplies % Net Service Revenue	17.6%	17.7%	17.5%
Efficiency - Expense/CMAA	\$ 12,040	\$ 11,270	\$ 12,070

** Reflects 2015 year-to-date results from entities that have been affiliated with Providence for more than 12 months.*

Year-to-date operating expenses were 15.6 percent higher than the prior year, which followed the 15.6 increase in operating revenue. Fees from provider tax related programs were \$528 million in 2015 while no related expenses were recorded in 2014. Timing of program approval by regulating agencies resulted in all 2014 related expenses totaling \$190 million being recorded in 2015. Expense growth was correlated with the higher patient volumes experienced in 2015. After removing the impact of provider fee taxes, growth of salary expenses and supply expenses outpaced operating expenses on a percentage basis, while benefits expenses and depreciation grew at a slower pace.

Year-to-date labor expense, defined as the combination of salaries and wages, employee benefits, and purchased services, was \$1.0 billion or 13.4 percent higher than the prior year. Full-time equivalents (FTEs) of 70.4 thousand increased 7.6 percent, which represented an increase of 5.0 thousand FTEs. Labor expense growth outpaced FTEs in part due to high utilization of agency labor in 2015 to staff open positions. Agency labor increased 69 million or 42.3 percent in 2015 compared to the prior year. Higher salary expense was also a reflection of strategic investments made to move Providence to an institutes model of management. Total salary expense increased 14.0 percent while total benefits expense increased 11.3 percent compared to the prior year. Per member per month (PMPM) employee medical costs in 2015 were 3.8 percent higher over the prior year in part due to higher pharmaceutical costs.

Supply expenses increased \$279 million or 15.6 percent compared to the prior year, but decreased slightly as a percentage of total net service revenue from 17.7 percent in 2014 to 17.6 percent in 2015. Medical supply expenses, a component of total supply expenses, increased 8.7 percent compared to the prior year which was in line with the growth in volume increases. Pharmaceutical expenses, the other significant component of supply expense, increased 30.4 percent compared to the prior year. Just under a third of the increase was volume driven with the remainder a result of price increases. Ten drugs accounted for 33 percent of the year-over-year price inflation from wholesaler drug purchases. Particularly high inflation was experienced among sole-source generic drugs and specialty pharmaceuticals. Market forces continue to move toward consolidation of generic drug producers, leading to significant price increases. In 2015 half of drugs purchased by Providence were branded drugs for which we have no ability to negotiate discounted rates. Continued consolidations of generic



drug producers is reducing the availability of options in the generics market by converting low cost generics to sole source branded suppliers.

Non-operating Income

Non-operating gains and losses are primarily comprised of investment income, pension settlement costs, and innovation projects expense. Pension settlement costs and innovation expenses were \$34 million and \$27 million through December, respectively. The remaining balance of non-operating income was driven by investment losses for the year, which were \$114 million as compared to \$178 million in positive investment income in 2014.

Investment Performance

Allocation by Asset Class <i>(Dollar figures presented in millions)</i>	Providence 12/31/15 Balance	Percent Allocation	Annual Return
Equities	\$1,314	23%	\$(54)
Fixed income	2,231	38%	2
Alternative Investments	861	15%	(66)
Cash & Other	1,396	24%	4
Total	\$5,802	100%	\$(114)

Within our portfolio, we saw growth hedge funds and our public and private debt positions outperform their respective indices for the year. Assets underperformed largely due to current allocations to Master Limited Partnerships (MLPs), Risk Parity and Commodities.

On a year-to-date basis, consolidated asset investments returned -3.22 percent, compared to the policy benchmark return of -2.54 percent. On a relative basis, our public equity pool returned -4.72 percent, driven by severe underperformance in Risk Parity, compared to the MSCI AC World IMI index return of -2.19 percent. Fixed income assets for the year returned 0.95 percent compared to the Barclays US Aggregate Index annual return of 0.55 percent; and our Alternative Investments returned 1.48 percent compared to our Alternative Investment Composite benchmark return of 1.03 percent.

Credit Agency Ratings

Providence received affirmation on the following ratings from the three national credit rating agencies during the latest round of reviews in June and July.

- Fitch: "AA"
- Standard and Poor's: "AA-"
- Moody's: "Aa3"

Ratings from all three agencies remained unchanged from the prior year, and all agencies issued a stable outlook based on improved year-over-year operating performance and stable balance sheet measures.

Debt Supported by Self-Liquidity

PH&S has authorized \$200 million in taxable commercial paper that is supported by self-liquidity. As of December 31, 2015, \$125 million in commercial paper was outstanding.

The System reports monthly on its cash and investment balances available to retire maturing short-term debt in the event notes cannot be remarketed. The table below summarizes the information provided to the rating agencies at the end of the fourth quarter describing cash and investments that could be available for liquidation.

Standard & Poor's Liquidity Assessment Coverage Calculation Spreadsheet (Last Revised January 2010)

INSTRUCTIONS: Fill in Green Cells to Compute Coverage Amounts

Liquidity Assessment Provider Name: Providence Health & Services
 Portfolio As of Date: December 31, 2015

Asset Allocation (Security Type)	Assets (\$ millions) with same day liquidity (T+0)	Assets (\$ millions) with next day liquidity (T+1)	Assets (\$ millions) with > same day liquidity (T+2, T+3,... T+n)	\$ in Millions	Discount Factor	Discounted Assets
Cash & Cash Equivalents *	\$ 524.03	\$ -	\$ -	\$ 524.03	1.00	\$ 524.03
S&P rated money market funds (> Am)	\$ 206.41	\$ -	\$ -	\$ 206.41	1.00	\$ 206.41
Highly rated (A-1 or A-1+) dedicated bank line	\$ -	\$ -	\$ -	\$ -	1.00	\$ -
Highly rated (A-1 or A-1+) money market instruments (< 1yr)	\$ -	\$ 4.01	\$ -	\$ 4.01	0.91	\$ 3.64
U.S. Treasury Debt Obligations (> 1 year)	\$ -	\$ 304.34	\$ -	\$ 304.34	0.91	\$ 276.67
U.S. TIPS	\$ -	\$ 94.25	\$ -	\$ 94.25	0.87	\$ 81.95
U.S. Agencies (> 1 year)	\$ -	\$ 95.97	\$ -	\$ 95.97	0.83	\$ 79.97
Investment Grade Debt (that is not included above)	\$ -	\$ -	\$ 229.16	\$ 229.16	0.67	\$ 152.78
Equities**	\$ -	\$ -	\$ 393.41	\$ 393.41	0.50	\$ 196.71
Non-Investment Grade Debt	\$ -	\$ -	\$ 6.87	\$ 6.87	0.40	\$ 2.75
Total	\$ 730.44	\$ 498.56	\$ 629.45	\$ 1,858.44		\$ 1,524.91
Discounted Total	\$ 730.44	\$ 442.24	\$ 352.23			Discounted Total

	Enter amount of Self Liquidity Backed Debt with:		
	Same Day Notice	Next Day Notice	> Next Day Notice
Commercial Paper		\$ 100.00	\$ 100.00
Variable Rate Demand Note or Obligation	\$ -		\$ -
Fixed Rate Debt			
Other Securities			
Total	\$ -	\$ 100.00	\$ 100.00
Remaining Discounted Assets	\$ 730.44	\$ 1,072.68	\$ 1,324.91
	Same Day +/- Sufficient	Next Day +/- Sufficient	> Next Day +/- Sufficient

TOTAL DEBT SUPPORTED BY SELF LIQUIDITY	TOTAL REMAINING DISCOUNTED ASSETS
↓	↓
\$ 200.00	\$ 1,324.91

Performance Metrics

December 31, 2015

	Year-To-Date Actual	Year-To-Date Budget	Year-To-Date Last Year
<u>Volume:</u>			
Acute Adjusted Admissions	651,198	630,518	602,468
Total Acute Admissions	361,689	352,410	333,263
Total Acute Patient Days	1,630,317	1,561,749	1,495,451
Acute Outpatient Visits	8,484,580	8,297,727	8,005,170
Observations	56,353	58,908	57,965
Primary Care Visits	7,741,961	7,789,622	6,881,113
Long-Term Care Patient Days	410,672	420,836	411,517
Home Health Visits	697,040	679,430	667,708
Hospice Days	642,506	663,325	628,182
Housing and Assisted Living Days	568,913	525,451	564,110
Health Plan Members	513,113	461,681	436,930
Total Occupancy %	64.8%	62.4%	59.5%
Total Average Daily Census	4,467	4,279	4,097
<u>Surgeries:</u>			
Inpatient	115,639	112,853	106,414
Outpatient	128,263	119,803	120,890
Total Surgeries	243,902	232,656	227,304
<u>Emergency Room Visits:</u>			
Inpatient	195,313	189,860	179,129
Outpatient	1,261,493	1,176,269	1,152,536
Total Emergency visits	1,456,806	1,366,129	1,331,665
<u>Outpatient Visits:</u>			
Outpatient Surgery	128,263	119,803	120,890
Emergency Visits	1,261,493	1,176,269	1,152,536
Primary Care	7,741,961	7,789,622	6,881,113
Homecare Visits	697,040	679,430	667,708
Observations	56,353	58,908	57,965
All Other	7,038,471	6,942,748	6,673,778
Total Outpatient Visits	16,923,581	16,766,780	15,553,990

Performance Metrics

December 31, 2015

	Year-To-Date Actual	Year-To-Date Budget	Year-To-Date Last Year
<u>Efficiency:</u>			
FTE's	70,438	69,328	65,369
YTD Overall Case-Mix Index	1.5738	1.5635	1.5699
YTD Case-Mix Adj Admissions (CMAA)	1,024,874	985,840	945,794
YTD Acute Care LOS (case-mix adj)	2.9	2.8	2.9
YTD Net Svc Rev/CMAA	12,295	11,931	11,499
YTD Net Expense/CMAA	12,040	11,727	11,270
YTD Paid Hours/CMAA	143	146	140
YTD Productive Hours/CMAA	127	130	124
FTE's Per Adjusted Occupied Bed	8.76	9.06	8.62
<u>Financial Performance:</u>			
Operating Margin	1.8%	1.5%	1.8%
Total Margin	0.5%	3.5%	5.9%
EBIDA ('000)	864,158	1,341,871	1,132,694
EBIDA Margin	6.0%	9.9%	5.7%
R12 Days of Total Cash on Hand	159	156	183
Net Patient AR Days (3 mo rolling ave)	47	63	50
Ave Yearly Salary/FTE (w/o benefits)	84,950	83,353	82,171
Employee Benefits as a % of Salaries	22.7%	23.9%	23.2%
Salary Wages as a % of Net Op Rev	41.5%	42.5%	42.0%
Supplies as a % of Net Op Revenue	14.4%	13.7%	14.4%
YTD Supplies Expense/CMAA	2,022	1,886	1,895
YTD Med Supplies Exp/CMAA	1,077	1,045	1,073
Debt to Total Net Asset Ratio	33.8	30.6	33.8
Cash to Debt Ratio	138.1	131.4	130.9
Current Ratio	1.4	1.8	1.5
Bad Debt & Charity % Gross Svc Rev	2.2%	3.0%	2.8%
<u>Community Benefit: ('000)</u>			
Cost of Charity Care Provided	\$ 180,256	\$ 215,219	\$ 205,555
Medicaid Charity	537,894	460,180	443,622
Education and Research Programs	112,826	79,288	96,988
Unpaid Cost of Other Govt Programs	47	1,088	1,157
Negative Margin Services and Other Non-Billed Services	68,095	61,507	57,355
	52,206	26,025	43,806
Total Community Benefit	\$ 951,324	\$ 843,307	\$ 848,483



PROVIDENCE HEALTH & SERVICES

Combined Financial Statements

December 31, 2015 and 2014

(With Independent Auditors' Report Thereon)



KPMG LLP
Suite 2900
1918 Eighth Avenue
Seattle, WA 98101

Independent Auditors' Report

The Board of Directors
Providence Health & Services:

We have audited the accompanying combined financial statements of Providence Health & Services, which comprise the combined balance sheets as of December 31, 2015 and 2014, and the related combined statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Combined Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly in all material respects, the financial position of Providence Health & Services as of December 31, 2015 and 2014, and the results of their operations and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.



Other Matter

Our audits were conducted for the purpose of forming an opinion on the combined financial statements as a whole. The supplemental information, included on pages 38 and 39 is presented for the purpose of additional analysis and is not a required part of the combined financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the combined financial statements. The information has been subjected to the auditing procedures applied in the audit of the combined financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the combined financial statements or to the combined financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the combined financial statements as a whole.

KPMG LLP

Seattle, Washington
March 9, 2016

PROVIDENCE HEALTH & SERVICES

Combined Balance Sheets

December 31, 2015 and 2014

(In thousands of dollars)

Assets	2015	2014
Current assets:		
Cash and cash equivalents	\$ 729,321	1,237,337
Short-term management-designated investments	200,251	199,338
Accounts receivable, less allowance for bad debts of \$343,835 in 2015 and \$289,908 in 2014	1,569,827	1,419,495
Other receivables, net	399,291	375,185
Supplies inventory	194,619	185,821
Other current assets	140,836	203,337
Current portion of funds held by trustee	54,740	76,365
Total current assets	<u>3,288,885</u>	<u>3,696,878</u>
Assets whose use is limited:		
Management-designated cash and investments	4,930,858	4,601,153
Gift annuities, trusts, and other	93,804	53,954
Funds held by trustee	272,902	179,473
Assets whose use is limited, net of current portion	<u>5,297,564</u>	<u>4,834,580</u>
Property, plant, and equipment, net	6,580,860	6,622,566
Other assets	572,968	568,884
Total assets	<u>\$ 15,740,277</u>	<u>15,722,908</u>

See accompanying notes to combined financial statements.

PROVIDENCE HEALTH & SERVICES

Combined Balance Sheets

December 31, 2015 and 2014

(In thousands of dollars)

Liabilities and Net Assets	<u>2015</u>	<u>2014</u>
Current liabilities:		
Current portion of long-term debt	\$ 244,532	202,287
Master trust debt classified as short-term	137,500	12,500
Accounts payable	427,567	521,942
Accrued compensation	641,406	738,075
Payable to contractual agencies	104,651	151,778
Retirement plan obligations	190,278	185,517
Current portion of self-insurance liability	118,898	108,943
Other current liabilities	463,198	465,865
Total current liabilities	<u>2,328,030</u>	<u>2,386,907</u>
Long-term debt, net of current portion	3,729,795	3,844,262
Other long-term liabilities:		
Self-insurance liability, net of current portion	292,843	274,541
Pension benefit obligation	1,063,581	1,040,939
Other liabilities	290,380	227,099
Total other long-term liabilities	<u>1,646,804</u>	<u>1,542,579</u>
Total liabilities	<u>7,704,629</u>	<u>7,773,748</u>
Net assets:		
Unrestricted:		
Controlling interest	7,541,875	7,492,324
Noncontrolling interest	44,904	45,302
Temporarily restricted	324,891	305,277
Permanently restricted	123,978	106,257
Total net assets	<u>8,035,648</u>	<u>7,949,160</u>
Total liabilities and net assets	<u>\$ 15,740,277</u>	<u>15,722,908</u>

See accompanying notes to combined financial statements.

PROVIDENCE HEALTH & SERVICES

Combined Statements of Operations

Years ended December 31, 2015 and 2014

(In thousands of dollars)

	2015	2014
Operating revenues:		
Net patient service revenues	\$ 11,969,116	10,294,637
Provision for bad debts	(185,567)	(193,018)
Net patient service revenues less provision for bad debts	11,783,549	10,101,619
Premium and capitation revenues	1,862,236	1,682,968
Other revenues	787,996	696,390
Total operating revenues	14,433,781	12,480,977
Operating expenses:		
Salaries and wages	5,983,719	5,248,196
Employee benefits	1,357,703	1,220,078
Purchased healthcare	1,045,019	909,154
Professional fees	582,600	514,990
Supplies	2,072,005	1,792,707
Purchased services	1,105,189	977,247
Depreciation	630,537	676,357
Interest	153,480	155,343
Amortization	720	5,671
Other	1,240,993	762,082
Total operating expenses	14,171,965	12,261,825
Excess of revenues over expenses from operations	261,816	219,152
Net nonoperating (losses) gains:		
Gain from affiliations	—	476,110
Loss on extinguishment of debt	(69)	(85,522)
Investment (losses) income, net	(113,617)	178,043
Pension settlement costs and other	(71,305)	(16,361)
Total net nonoperating (losses) gains	(184,991)	552,270
Excess of revenues over expenses	76,825	771,422
Net assets released from restriction for capital	20,372	13,646
Change in noncontrolling interests in consolidated joint ventures	(398)	584
Pension related changes	(27,415)	(249,011)
Contributions, grants, and other	(20,231)	(8,639)
Increase in unrestricted net assets	\$ 49,153	528,002

See accompanying notes to combined financial statements.

PROVIDENCE HEALTH & SERVICES
 Combined Statements of Changes in Net Assets
 Years ended December 31, 2015 and 2014
 (In thousands of dollars)

	<u>Unrestricted: controlling interest</u>	<u>Unrestricted: noncontrolling interest</u>	<u>Temporarily restricted</u>	<u>Permanently restricted</u>	<u>Total net assets</u>
Balance, December 31, 2013	\$ 6,964,906	44,718	223,548	84,313	7,317,485
Excess of revenues over expenses	771,422	—	—	—	771,422
Restricted contributions from affiliations	—	—	50,401	14,515	64,916
Contributions, grants, and other	(8,639)	—	93,563	7,429	92,353
Net assets released from restriction	13,646	—	(62,235)	—	(48,589)
Change in noncontrolling interests in consolidated joint ventures	—	584	—	—	584
Pension related changes	(249,011)	—	—	—	(249,011)
Increase in net assets	<u>527,418</u>	<u>584</u>	<u>81,729</u>	<u>21,944</u>	<u>631,675</u>
Balance, December 31, 2014	<u>7,492,324</u>	<u>45,302</u>	<u>305,277</u>	<u>106,257</u>	<u>7,949,160</u>
Excess of revenues over expenses	76,825	—	—	—	76,825
Contributions, grants, and other	(20,231)	—	88,214	17,721	85,704
Net assets released from restriction	20,372	—	(68,600)	—	(48,228)
Change in noncontrolling interests in consolidated joint ventures	—	(398)	—	—	(398)
Pension related changes	(27,415)	—	—	—	(27,415)
Increase in net assets	<u>49,551</u>	<u>(398)</u>	<u>19,614</u>	<u>17,721</u>	<u>86,488</u>
Balance, December 31, 2015	<u>\$ 7,541,875</u>	<u>44,904</u>	<u>324,891</u>	<u>123,978</u>	<u>8,035,648</u>

See accompanying notes to combined financial statements.

PROVIDENCE HEALTH & SERVICES

Combined Statements of Cash Flows

Years ended December 31, 2015 and 2014

(In thousands of dollars)

	<u>2015</u>	<u>2014</u>
Cash flows from operating activities:		
Increase in net assets	\$ 86,488	631,675
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Gains from affiliations	—	(541,026)
Depreciation and amortization	631,257	682,028
Provision for bad debt	185,567	193,018
Loss on extinguishment of debt	69	85,522
Equity income from joint ventures	(40,871)	(39,159)
Restricted contributions and investment income received	(112,763)	(94,024)
Net realized and unrealized losses (gains) on investments	187,912	(109,622)
Distributions from joint ventures	47,424	37,687
Changes in certain current assets and current liabilities	(492,347)	(21,062)
Change in certain long-term assets and liabilities	104,225	266,280
Net cash provided by operating activities	<u>596,961</u>	<u>1,091,317</u>
Cash flows from investing activities:		
Property, plant, and equipment additions	(637,262)	(537,301)
Proceeds from disposal of property, plant, and equipment	8,354	6,901
Purchases of investments	(6,851,705)	(5,555,329)
Proceeds from sales of investments	6,293,325	5,340,773
Change in other long-term assets and other	(12,463)	11,199
Change in funds held by trustee, net	(71,804)	(35,630)
Cash paid for affiliations, net of cash acquired	—	(98,958)
Net cash used in investing activities	<u>(1,271,555)</u>	<u>(868,345)</u>
Cash flows from financing activities:		
Proceeds from restricted contributions and restricted income	112,763	94,024
Debt borrowings	453,088	1,193,228
Debt payments	(400,379)	(1,112,836)
Other financing activities	1,106	(13,016)
Net cash provided by financing activities	<u>166,578</u>	<u>161,400</u>
(Decrease) increase in cash and cash equivalents	<u>(508,016)</u>	<u>384,372</u>
Cash and cash equivalents, beginning of year	<u>1,237,337</u>	<u>852,965</u>
Cash and cash equivalents, end of year	\$ <u>729,321</u>	\$ <u>1,237,337</u>
Supplemental disclosure of cash flow information:		
Cash paid for interest (net of amounts capitalized)	\$ 141,554	136,066

See accompanying notes to combined financial statements.

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

(1) Organization

(a) *Sisters of Providence*

Sisters of Providence (the Congregation), a religious congregation of Roman Catholic women, was founded in 1843. The religious congregation's central headquarters is in Montreal, Quebec, Canada. Sisters of Providence – Mother Joseph Province (the Province) was formed in 2000 through the combination of the Sacred Heart Province (founded in 1856) and the St. Ignatius Province (founded in 1891). The activities of the Province include apostolic works in healthcare, social services, and education. Members of the Province serve in these works through related and unrelated organizations. The Province is compensated for the services of its members. The Province has 130 professed members and maintains provincial administration offices in Renton, Washington. The members of the Province represent the Congregation in the following:

- Archdiocese of Los Angeles, California
- Archdiocese of Portland, Oregon
- Archdiocese of Seattle, Washington
- Diocese of Cubao, Philippines
- Diocese of Orlando, Florida
- Diocese of Spokane, Washington
- Diocese of Yakima, Washington
- Diocesis Santiago de Maria, El Salvador

(b) *Providence Health & Services*

The Public Juridic Person, Providence Ministries, is the sole Member of Providence Health & Services and controls certain aspects of the various corporations comprising Providence Health & Services through certain reserved rights.

Providence Ministries sponsors various corporations comprising Providence Health & Services including:

- Providence Health & Services – Washington
- Providence Health & Services – Oregon
- Providence Health System – Southern California (cosponsored by the Congregation and the American Province of the Little Company of Mary Sisters)
- Providence Health & Services – Montana
- Providence St. Joseph Medical Center
- St. Thomas Child and Family Center Corporation
- University of Great Falls

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

- Providence Plan Partners
- Providence Health Plan (the Health Plan)
- Providence Health Assurance
- Providence Health System Housing; The St. Luke Association; The Lundberg Association; Providence St. Francis Association; Providence Blanchet Association; Providence Rossi Association; Providence Peter Claver Association; The Gamelin Association; The Gamelin Oregon Association; The Gamelin California Association; Providence St. Elizabeth House Association; Gamelin Washington Association; Providence Gamelin House Association
- Providence Oregon Management Corporation
- Providence Ventures, Inc.
- Providence Assurance, Inc.
- Inland Northwest Health Services

Providence Ministries and Western HealthConnect are co-Members of Providence Health & Services – Western Washington.

Western HealthConnect, a secular Washington nonprofit corporation, is the sole corporate member of the following organizations:

- Swedish Health Services
- Swedish Edmonds
- Kadlec Regional Medical Center
- PacMed Clinics D/B/A Pacific Medical Centers
- Western HealthConnect Ventures, Inc.
- Health Connect Partners

Providence Health & Services and Western HealthConnect, inclusive of all sponsored and corporate members, are collectively referred to as the Health System.

The Health System owns or operates 34 general acute care hospitals, three ambulatory care centers, six medical groups, six long-term care facilities, seven homecare and hospice entities, five assisted living facilities, a high school, a university, 13 low-income housing projects, the Health Plan, a health services contractor, two programs of all inclusive care for the elderly, and 23 controlled fundraising foundations.

The Health System provides inpatient, outpatient, primary care, and home care services in Alaska, Washington, Montana, Oregon, and Southern California. The Health System operates these businesses primarily in the greater metropolitan areas of Anchorage, Alaska; Seattle, Spokane, Kennewick, and Olympia, Washington; Missoula, Montana; Portland and Medford, Oregon; and Los Angeles, California.

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

(c) Tax Exempt Status

The Health System and substantially all of the various corporations within the Health System have been recognized as exempt from federal income taxes, except on unrelated business income, under Section 501(a) of the Internal Revenue Code (IRC) as an organization described in Section 501(c)(3) of the IRC.

Providence Plan Partners, Providence Health Plan, and Providence Health Assurance are not-for-profit entities and have been recognized as exempt from federal income taxes, except on unrelated business income, as social welfare organizations under Section 501(c)(4) of the IRC.

(d) Organizational Changes

Affiliation Activity

Effective March 1, 2014, the Health System entered into an affiliation agreement with Sisters of Charity of Leavenworth Health System (SCL) to transfer sponsorship of Saint John's Health Center (Saint John's) to the Health System. Saint John's operates a nonprofit medical center, a cancer institute, and physician clinics to serve the Santa Monica, California community and surrounding area. The fair value of the net assets acquired was \$430,728,000, which included \$64,487,000 in restricted net assets. Unrestricted net assets of \$366,241,000 exceeded total cash consideration of \$186,217,000. The Health System recognized a gain from affiliation in the amount of \$180,024,000 as the excess of the fair value of the unrestricted net assets over total consideration. The \$64,487,000 of restricted net assets is recorded in restricted net assets in the combined statement of changes in net assets. The results of operations of Saint John's entities have been included in the combined statements of operations of the Health System effective as of the date of affiliation during 2014.

Effective May 1, 2014, the Health System entered into an affiliation agreement with PacMed Clinics (PacMed). PacMed is a private, nonprofit, multi-specialty medical group with nine clinics in the Puget Sound area and more than 150 primary care and specialty providers at the date of affiliation. Pursuant to the affiliation agreement, Western HealthConnect became PacMed's sole corporate Member. No cash or other purchase consideration was transferred to effect the affiliation. The results of operations of PacMed entities have been included in the combined statements of operations of the Health System effective as of the date of affiliation. The affiliation resulted in an excess of assets acquired over liabilities assumed, or a contribution from PacMed to the Health System of \$84,717,000, which is included in gain from affiliation during 2014.

Effective June 13, 2014, the Health System entered into an affiliation agreement with Kadlec Health System (Kadlec). Kadlec operates a nonprofit medical center, a neurological resource center, a supporting foundation, and physician clinics to serve the area of Kennewick, Pasco, and Richland, Washington. Pursuant to the affiliation agreement, Western HealthConnect became the sole member of Kadlec. No cash or other purchase consideration was transferred to effect the affiliation. The results of operations of Kadlec have been included in the combined statements of operations of the Health System effective as of the date of affiliation. The affiliation resulted in an excess of assets acquired over liabilities assumed, or a contribution from Kadlec to the Health System of \$211,798,000. The unrestricted portion of the contribution of \$211,369,000 is included in gain from affiliation in the

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

accompanying combined statement of operations. The remaining \$429,000 of the contribution is recorded in restricted net assets in the combined statement of changes in net assets during 2014.

The financial results of the affiliated entities discussed above are included in the Health System's 2014 combined statement of operations from the effective date of each respective affiliation through December 31, 2014. The following table summarizes the aggregate amounts included in the 2014 combined statement of operations (in thousands of dollars) related to the affiliated entities, excluding gain from affiliations:

Total operating revenues	\$	648,634
Excess of revenues over expenses from operations		52,151
Excess of revenues over expenses		39,369

The following table summarizes the aggregate amounts included in the December 31, 2014 combined balance sheets related to the affiliated entities discussed above (in thousands of dollars):

Cash and investments	\$	201,534
Accounts receivable, net of allowances		103,444
Property, plant, and equipment, net		594,323
Other assets		189,408
Total assets	\$	<u>1,088,709</u>
Accounts payable and accrued compensation	\$	93,604
Long-term debt, net of current portion		343,614
Other liabilities		97,571
Total liabilities		<u>534,789</u>
Net assets		<u>553,920</u>
Total liabilities and net assets	\$	<u>1,088,709</u>

(2) Summary of Significant Accounting Policies

(a) Basis of Presentation

The financial statements of the Health System are presented on a combined basis due to the operational interdependence of the organization and because the respective Boards of Directors and corporate officers of Providence Health & Services and Western HealthConnect are comprised of the same individuals. All significant transactions and accounts between divisions and combined affiliates of the Health System have been eliminated. The Health System has performed an evaluation of subsequent events through March 9, 2016, which is the date these combined financial statements were issued.

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

(b) Use of Estimates

The preparation of the combined financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the combined financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(c) Cash and Cash Equivalents

Cash and cash equivalents include investments in highly liquid debt instruments with an original or remaining maturity of three months or less when acquired.

(d) Supplies Inventory

Supplies inventory is stated at the lower of cost (first-in, first-out) or market.

(e) Property, Plant, and Equipment

Property, plant, and equipment are stated at cost. Improvements and replacements of plant and equipment are capitalized. Maintenance and repairs are expensed. The cost of the property, plant, and equipment sold or retired and the related accumulated depreciation are removed from the accounts, and the resulting gain or loss is recognized at the time of disposal.

The Health System assesses potential impairment to their long-lived assets when there is evidence that events or changes in circumstances have made recovery of the carrying value of the assets unlikely. An impairment loss, equal to the excess, if any, of the carrying value over the fair value less disposal costs, is recognized when the sum of the expected future undiscounted net cash flows from the use and disposal of the asset is less than the carrying amount of the asset.

(f) Depreciation

The provision for depreciation is determined by the straight-line method, which allocates the cost of tangible property equally over its estimated useful life or lease term.

(g) Capitalized Interest

Interest capitalized on amounts expended during construction is a component of the cost of additions to be allocated to future periods through the provision for depreciation. Capitalization of interest ceases when the addition is substantially complete and ready for its intended use. The Health System capitalized \$10,573,000 and \$4,044,000 of interest costs during the years ended December 31, 2015 and 2014, respectively.

(h) Financing Costs

Financing costs are recorded in other assets and are amortized using the effective-interest method over the term of the related debt, or to the earliest date at which a creditor can demand payment.

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

(i) Goodwill and Indefinite Lived Intangible Assets

Goodwill and indefinite lived intangible assets, which are not amortized as they are considered to have an indefinite life, are recorded in other assets as the excess of cost over fair value of the acquired net assets. Goodwill and indefinite lived intangible assets are tested at least annually for impairment.

(j) Intangible Assets with a Finite Life

Intangible assets that are determined to have a finite life are recorded in other assets. Such assets are amortized by the straight-line method, which allocates the cost of tangible property equally over the asset's estimated useful life or agreement term.

(k) Assets Whose Use Is Limited

The Health System has designated all of its investments in debt and equity securities, hedge funds, and collective investment funds as trading. These investments are reported on the combined balance sheets at fair value.

Assets whose use is limited primarily include assets held by trustees under indenture agreements, self-insurance funds, funds held for the payment of health plan medical claims and other statutory reserve requirements, assets held by related foundations, and designated assets set aside by the management of Providence Health & Services for future capital improvements and other purposes, over which management retains control.

Assets held by trustee obtained from borrowings under the Health System's master trust indenture for construction and other ongoing projects were \$133,594,000 and \$51,433,000 as of December 31, 2015 and 2014, respectively. Assets held by trustee for purposes of funding future obligations related to certain self-insurance programs and retirement plans were \$171,075,000 and \$190,819,000 at December 31, 2015 and 2014, respectively.

(l) Net Assets

Unrestricted net assets are those that are not subject to donor-imposed stipulations. Amounts related to the Health System's noncontrolling interests in certain joint ventures are included in unrestricted net assets. Temporarily restricted net assets are those whose use by the Health System has been limited by donors to a specific time period and/or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Health System in perpetuity. Unless specifically stated by donors, gains and losses on temporarily and permanently restricted net assets are recorded as temporarily restricted.

(m) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Health System are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted contributions if they are received with donor stipulations that limit the use of the donated assets. When the terms of a donor restriction are met, temporarily restricted net assets are reclassified as unrestricted net assets and reported as other operating revenues in the combined statements of operations or changes in net assets as net assets released from restriction.

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

(n) Net Patient Service Revenues

The divisions of the Health System have agreements with governmental and other third-party payors that provide for payments to the divisions at amounts different from the Health System's established charges. Payment arrangements for major third-party payors may be based on prospectively determined rates, reimbursed cost, discounted charges, per diem payments, predetermined rates per HMO enrollee per month, or other methods.

Net patient service revenues are reported at the estimated net realizable amounts due from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with governmental payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as appropriate. Adjustments from finalization of prior years' cost reports and other third-party settlement estimates resulted in an increase in net patient service revenues of \$44,786,000 and \$31,098,000 for the years ended December 31, 2015 and 2014, respectively.

The composition of significant third-party payors for the years ended December 31, 2015 and 2014, as a percentage of net patient service revenues, is as follows:

	<u>2015</u>	<u>2014</u>
Commercial	50%	52%
Medicare	32	33
Medicaid	17	14
Self-pay	1	1
	<u>100%</u>	<u>100%</u>

(o) Provision for Bad Debts

The Health System provides for an allowance against patient accounts receivable for amounts that could become uncollectible. The Health System estimates this allowance based on the aging of accounts receivable, historical collection experience by payor, and other relevant factors. There are various factors that can impact the collection trends, such as changes in the economy, which in turn have an impact on unemployment rates and the number of uninsured and underinsured patients, the increased burden of copayments to be made by patients with insurance coverage and business practices related to collection efforts. These factors continuously change and can have an impact on collection trends and the estimation process used by the Health System. The Health System records a provision for bad debts in the period of services on the basis of past experience, which has historically indicated that many patients are unresponsive or are otherwise unwilling to pay the portion of their bill for which

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

they are financially responsible. The estimates made and changes affecting those estimates for the years ended December 31, 2015 and 2014 are summarized below:

	2015	2014
	(In thousands of dollars)	
Changes in allowance for doubtful accounts:		
Allowance for doubtful accounts at beginning of year	\$ 289,908	358,966
Write-off of uncollectible accounts, net of recoveries	(131,640)	(262,076)
Provision for bad debts	185,567	193,018
Allowance for doubtful accounts at end of year	\$ 343,835	289,908

(p) Premium Revenues, Premiums Receivable, Unearned Premiums, and Capitation Revenues

Health plan revenues consist of premiums paid by employers, individuals, and agencies of the federal and state governments for healthcare services. Health plan revenues are received on a prepaid basis and are recognized as revenue during the month for which the enrolled member is entitled to healthcare services. Premiums received for future months are recorded as unearned premiums.

Similar to health plan premiums, capitation revenues are received on a prepaid basis and are recognized as revenue during the month for which the enrolled member is entitled to healthcare services.

(q) Other Operating Revenues

Other operating revenues include meaningful use revenue, rental revenue, equity earnings from joint ventures, contributions released from restrictions, cafeteria revenue, and other miscellaneous revenue.

(r) Charity and Un-sponsored Community Benefit Costs

The divisions of the Health System have policies that provide for serving those without the ability to pay. The policies also provide for discounted sliding scale payments based on the income and assets of the person responsible for the bill. In addition to uncompensated care, the Health System's divisions also provide services that benefit the poor and others in the communities they serve.

Information for the Health System for the years ended December 31, 2015 and 2014 is summarized below:

	2015	2014
	(In thousands of dollars)	
Cost of charity care provided	\$ 180,256	205,555
Unpaid cost of Medicaid services	537,894	443,623
Un-sponsored community benefit costs	\$ 718,150	649,178

The cost of charity care provided is calculated based on each division's aggregate relationship of costs to charges. The unpaid cost of Medicaid services is the cost of treating Medicaid patients in excess of government payments. Unpaid cost of Medicaid services are net of revenues of \$1,552,853,000 and \$1,377,866,000 for the years ended December 31, 2015 and 2014, respectively.

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

(s) *Net Nonoperating Losses and Gains*

Net nonoperating gains primarily include investment income from trading securities, income from recipient organizations, pension settlement costs, and other income. Additionally, contributions from affiliations with Saint John's, PacMed, and Kadlec are included in net nonoperating gains in 2014.

(t) *Excess of Revenues over Expenses*

Excess of revenues over expenses includes all changes in unrestricted net assets, except for net assets released from restriction for the purchase of property, certain changes in funded status of postretirement benefit plans, net changes in noncontrolling interests in combined joint ventures, and other.

(u) *Income and Other Taxes*

The Health System recognizes the effect of income tax positions only if those positions are more likely than not of being sustained upon an audit by the taxing authority. Recognized income tax positions are measured at the largest amount that is greater than 50% likely of being realized. Changes in recognition or measurement are reflected in the period in which the change in judgment occurs.

Various states in which the Health System operates have instituted a provider tax on certain patient service revenues at qualifying hospitals to increase funding from other sources and obtain additional Federal funds to support increased payments to providers for Medicaid services. These taxes are included in other expenses in the accompanying combined statements of operations and were \$527,789,000 and \$129,384,000 for the years ended December 31, 2015 and 2014, respectively. These programs resulted in enhanced payments from these states in the way of lump-sum payments and per claim increases. These enhanced payments are included in net patient service revenues in the accompanying combined statements of operations and were \$612,282,000 and \$129,349,000 for the years ended December 31, 2015 and 2014, respectively.

(v) *Recently Issued or Adopted Accounting Standards*

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update No. (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)*, to clarify the principles for recognizing revenue and to improve financial reporting by creating common revenue recognition guidance for GAAP and International Financial Reporting Standards. The core principle of the new guidance is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The amendments in the ASU can be applied either retrospectively to each prior reporting period presented or retrospectively with the cumulative effect of initially applying the update recognized at the date of the initial application along with additional disclosures. The Health System is currently evaluating the impact of ASU 2014-09, including the methods of implementation, which is effective for the fiscal year beginning on January 1, 2018.

In March 2015, the FASB issued ASU 2015-03, *Simplifying the Presentation of Debt Issuance Costs*. This update changes the presentation of debt issuance costs in the financial statements. Under the ASU, an entity presents such costs in the balance sheet as a direct deduction from the recognized liability rather than as an asset. Amortization of the costs is reported as interest expense. The Health System

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

has considered the provisions of this standard and will adopt in the fiscal year beginning January 1, 2016. The Health System does not believe that the provisions of this standard will have a material impact in its combined financial statements.

In May 2015, the FASB issued ASU 2015-07, *Fair Value Measurement (Topic 820) – Disclosures for Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*, which eliminates the requirement to categorize investments in the fair value hierarchy if their fair value is measured at net asset value per share, or its equivalent, (NAV) using the practical expedient in the FASB's fair value measurement guidance. The Health System adopted this standard effective December 31, 2015. As a result of the adoption of the standard, the Health System modified its fair value hierarchy disclosures.

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842)*, which requires lessees to recognize a lease liability and a right of use asset for all lease obligations with exception to short-term leases. The lease liability will represent the lessee's obligation to make lease payments arising from the lease measured on a discounted basis and the right of use asset will represent the lessee's right to use or control the use of a specified asset for a lease term. The lease guidance also simplifies accounting for sale leaseback transactions. The Health System is currently evaluating the impact of ASU 2016-02, which is effective for the fiscal year beginning on January 1, 2019 with retrospective application to the earliest presented period.

(w) *Reclassifications*

Certain reclassifications have been made to prior year amounts to conform to the current year presentation.

(3) **Fair Value of Financial Instruments**

ASC Topic 820 (Topic 820), *Fair Value Measurements*, establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities that the Health System has the ability to access at the measurement date.
- Level 2 inputs are inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly.
- Level 3 inputs are unobservable inputs for the asset or liability.

The level in the fair value hierarchy within which a fair value measurement in its entirety falls is based on the lowest level input that is significant to the fair value measurement in its entirety.

The fair value of assets whose use is limited, other than those investments measured using NAV as a practical expedient for fair value, is estimated using quoted market prices or other observable inputs when quoted market prices are unavailable. For long-term debt, the fair value is based on Level 2 inputs, such as the

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

discounted value of the future cash flows using current rates for debt with the same remaining maturities, considering the existing call premium and protection. The carrying value and fair value of long-term debt, including accrued interest, was \$4,149,702,000 and \$4,438,718,000, respectively, as of December 31, 2015, and \$4,097,789,000 and \$4,421,616,000, respectively, as of December 31, 2014.

Other financial instruments of the Health System include cash and cash equivalents and other current assets and liabilities. The carrying amount of these instruments approximates fair value because these items mature in less than one year.

The following table presents the Health System's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in Topic 820 for the years ended December 31, 2015 and 2014 (in thousands of dollars):

Balance at December 31, 2013	\$	25,950
Total realized and unrealized gains (losses), net		(2,257)
Total purchases		1,418
Total sales		(1,072)
Transfers into Level 3		2,997
		<hr/>
Balance at December 31, 2014	\$	27,036
Total realized and unrealized gains (losses), net		(131)
Total purchases		30,398
Total sales		(2,258)
Transfers into Level 3		10,982
Transfers out of Level 3		(3,895)
		<hr/>
Balance at December 31, 2015	\$	<u>62,132</u>

There were no significant transfers between assets classified as Level 1 and Level 2 during the years ended December 31, 2015 and 2014.

Level 3 assets include charitable remainder trusts, real property and equity investments in healthcare technology start-ups through the Health System's innovation venture capital fund. Fair values of real property were estimated using a market approach. Fair values of charitable remainder trusts were estimated using an income approach. Fair value of equity investments in healthcare technology start-ups were estimated using a combination of income and market approach.

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

(4) Assets Whose Use is Limited

The composition of assets whose use is limited at December 31, 2015 is set forth in the following table:

	December 31, 2015	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
(In thousands of dollars)				
Management-designated				
cash and investments:				
Cash and cash equivalents	\$ 613,736	613,736	—	—
Domestic equity securities:				
Mutual funds:				
Large capitalization	183,018	183,018	—	—
Medium-small cap and other	149,291	149,291	—	—
Technology	133,510	133,510	—	—
Financial services	103,049	103,049	—	—
Consumer services	93,663	93,663	—	—
Other industries	196,044	196,044	—	—
Foreign equity securities:				
Mutual funds:				
Large capitalization	91,639	91,639	—	—
Medium-small cap and other	64,545	64,545	—	—
Other industries	68,034	68,034	—	—
Debt securities – U.S. Treasury	1,001,525	717,466	284,059	—
Debt securities – State Treasury	27,754	—	27,754	—
Domestic corporate debt securities	643,590	—	643,590	—
Foreign corporate debt securities	87,423	—	87,423	—
Other	272,782	515	272,267	—
Investments measured using NAV	1,401,506			
Total management-designated cash and investments	<u>\$ 5,131,109</u>			
Gift annuities, trusts, and other	<u>\$ 93,804</u>	23,856	7,816	62,132
Funds held by trustee:				
Cash and cash equivalents	\$ 176,134	176,134	—	—
Domestic equity securities	334	334	—	—
Foreign equity securities	162	162	—	—
Debt securities – U.S. Treasury	64,874	63,650	1,224	—
Domestic corporate debt securities	48,478	—	48,478	—
Foreign corporate debt securities	15,971	—	15,971	—
Collateralized debt securities	21,108	—	21,108	—
Other	581	87	494	—
Total funds held by trustee	<u>\$ 327,642</u>			

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

The composition of assets whose use is limited at December 31, 2014 is set forth in the following table:

	December 31, 2014	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
(In thousands of dollars)				
Management-designated cash and investments:				
Cash and cash equivalents	\$ 401,728	401,728	—	—
Domestic equity securities:				
Mutual funds:				
Large capitalization	139,544	139,544	—	—
Medium-small cap and other	143,501	143,501	—	—
Consumer services	269,565	269,565	—	—
Financial services	129,676	129,676	—	—
Technology	105,950	105,950	—	—
Other industries	120,761	120,761	—	—
Foreign equity securities:				
Mutual funds				
Large capitalization	177,185	177,185	—	—
Medium-small cap and other	39,315	39,315	—	—
Other industries	83,455	83,455	—	—
Debt securities – U.S. Treasury	1,211,814	1,054,362	157,452	—
Debt securities – State Treasury	21,926	81	21,845	—
Domestic corporate debt securities	532,840	—	532,840	—
Foreign corporate debt securities	96,487	—	96,487	—
Other	177,374	12,216	162,504	2,654
Investments measured using NAV	<u>1,149,370</u>			
Total management-designated cash and investments	<u>\$ 4,800,491</u>			
Gift annuities, trusts, and other	<u>\$ 53,954</u>	20,454	9,118	24,382
Funds held by trustee:				
Cash and cash equivalents	\$ 85,038	85,038	—	—
Domestic equity securities	22,159	22,159	—	—
Foreign equity securities:	1,900	1,900	—	—
Debt securities – U.S. Treasury	84,725	82,125	2,600	—
Domestic corporate debt securities	32,017	—	32,017	—
Foreign corporate debt securities	19,953	—	19,953	—
Mortgage-backed securities	5,956	—	5,956	—
Other	4,090	—	4,090	—
Total funds held by trustee	<u>\$ 255,838</u>			

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

The Health System participates in various funds that are not actively marketed on an open exchange. These investments consist of shares or units in investment funds as opposed to direct interests in the funds' underlying holdings, which may be marketable. Due to the nature of these funds the net asset value per share, or its equivalent, reported by each fund manager is used as a practical expedient to estimate the fair value of the Health System's interest therein. Management believes that the carrying amounts of these financial instruments, provided by the fund managers, are reasonable estimates of fair value.

The following table presents information for investments where the NAV was used to value the investments as of December 31 (in thousands of dollars):

	Fair value		Unfunded Commitments	Redemption frequency	Redemption notice period
	2015	2014			
Hedge funds					
Relative value	\$ 180,756	159,753	—	Quarterly	60 – 90 days
Risk parity	155,928	148,543	—	Monthly	5 – 15 days
Growth	169,490	151,218	—	Quarterly	45 – 90 days
Diversified	83,274	85,712	—	Monthly	2 – 90 days
Other	14,613	7,517	—	Monthly or Quarterly	30 – 90 days
Collective investment funds:					
Equities	572,214	522,009	—	Monthly	6 – 60 days
Fixed income	216,243	74,618	—	Daily	3 days
Private equity	8,988	—	75,408	Not applicable	Not applicable
Total	\$ <u>1,401,506</u>	<u>1,149,370</u>	<u>75,408</u>		

The following is a summary of the nature of these investments and their associated risks:

Hedge funds are portfolios of investments that use advanced investment strategies such as leveraged, long, short, and derivative positions in both domestic and international markets with the goal of diversifying portfolio risk and generating return. The Health System's investments in hedge funds include \$44,980,000 subject to lockup provisions that limit the Health System's ability to access cash for one or more years from the initial investment.

Collective investment funds are funds that pursue diversification of domestic and foreign equity and fixed income securities. The Health System's investments in collective investment funds have no lockup provisions or other restrictions, other than outlined in the table above, that limit its ability to access cash.

Private equity funds are funds that make opportunistic investments that are primarily private in nature. These investments cannot be redeemed by the Health System; rather the Health System has committed an amount to invest in the private funds over the respective commitment periods. After the commitment period has ended, the nature of the investments in this category is that the distributions are received through the liquidation of the underlying assets.

The Health System offsets the fair value of various investment derivative instruments when executed with the same counterparty under a master netting arrangement. The Health System invests in a variety of investment derivative instruments through a fixed-income manager that has executed a master netting arrangement with the counterparties of each of its futures and forward currency purchase and sale contracts

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

whereby the financial instruments held by the same counterparty are legally offset as the instruments are settled.

The following table presents gross investment derivative assets and liabilities reported on a net basis included in management-designated investments in the combined balance sheets:

	2015
	(In thousands of dollars)
Derivative assets:	
Futures contracts	\$ 404,677
Forward currency and other contracts	41,617
	446,294
Derivative liabilities:	
Futures contracts	(404,677)
Forward currency and other contracts	(42,289)
	(446,966)

Investment derivative instruments, reported in management-designated investments in the combined balance sheets, are recorded at fair value.

The Health System's management designated cash and investments include funds held on behalf of non-controlled entities of \$59,569,000 and \$0 at December 31, 2015 and 2014, respectively. An offsetting liability to recognize the obligation back to the non-controlled entities is included in other liabilities in the accompanying combined balance sheets.

Investment income from management-designated cash and investments and funds held by trustee are included in net nonoperating gains and are comprised of the following for the years ended December 31, 2015 and 2014:

	2015	2014
	(In thousands of dollars)	
Interest income	\$ 64,797	71,108
Net realized gains on sale of investments	25,280	365,413
Change in net unrealized losses on trading securities	(203,694)	(258,478)
Total	\$ (113,617)	178,043

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

(5) Property, Plant, and Equipment

Property, plant, and equipment and the total accumulated depreciation at December 31, 2015 and 2014 are shown below:

	Approximate useful life (years)	2015	2014
		<u>(In thousands of dollars)</u>	
Land	—	\$ 757,469	756,304
Buildings and improvements	5–60	5,834,374	5,643,827
Equipment:			
Fixed	5–25	1,055,751	1,041,956
Major movable and minor	3–20	4,405,945	4,138,703
Rental property	15–40	914,353	898,609
Construction in progress	—	274,883	216,549
		<u>13,242,775</u>	<u>12,695,948</u>
Less accumulated depreciation		<u>6,661,915</u>	<u>6,073,382</u>
Property, plant, and equipment, net		<u>\$ 6,580,860</u>	<u>6,622,566</u>

Construction in progress primarily represents renewal and replacement of various facilities in the Health System's operating divisions, as well as costs capitalized related to software development.

(6) Other Assets

Other assets at December 31, 2015 and 2014 are as follows:

	2015	2014
	<u>(In thousands of dollars)</u>	
Unamortized financing costs, net	\$ 34,639	35,744
Investment in nonconsolidated joint ventures	141,182	116,747
Interest in noncontrolled foundations	128,341	136,597
Notes receivable	45,889	37,989
Long-term reinsurance receivable	33,032	39,530
Goodwill and intangibles	169,584	163,540
Other	20,301	38,737
Total other assets	<u>\$ 572,968</u>	<u>568,884</u>

The Health System participates in various joint ventures for the purpose of furthering its healthcare mission. These joint ventures exist in all geographic locations in which the Health System operates. The primary purposes of the ventures are to provide outpatient services such as laboratory, outpatient surgery, and medical imaging. Various joint ventures, throughout the Health System, are controlled and consequently are

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

combined in the financial statements of the Health System. All other joint ventures are accounted for under the equity method of accounting. The Health System recorded earnings from equity method investees of \$40,871,000 and \$39,159,000 for the years ended December 31, 2015 and 2014, respectively, the majority of which are included in other operating revenues in the accompanying combined statements of operations.

(7) Short-Term and Long-Term Debt

The Health System has borrowed Master Trust debt issued through the following:

- California Health Facilities Financing Authority (CHFFA)
- Alaska Industrial Development and Export Authority (AIDEA)
- Hospital Facilities Authority of Multnomah County (HFAMC)
- Washington Health Care Facilities Authority (WHCFA)
- Montana Facility Finance Authority (MFFA)
- Oregon Facilities Authority (OFA)

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

Short-term and long-term unpaid principal at December 31, 2015 and 2014 consists of the following:

	<u>Maturing through</u>	<u>Coupon rates</u>	<u>Unpaid principal</u>	
			<u>2015</u>	<u>2014</u>
(In thousands of dollars)				
Master trust debt:				
Fixed:				
Series 1996, CHFFA Revenue Bonds	2015	4.00 – 6.00%	\$ —	2,035
Series 1997, Direct Obligation Notes	2017	7.70%	1,445	2,090
Series 2003H, AIDEA Revenue Bonds	2015	4.63 – 5.25%	—	4,600
Series 2005, Direct Obligation Notes	2030	4.31 – 5.39%	44,380	46,295
Series 2006A, WHCFA Revenue Bonds	2036	4.50 – 5.00%	210,555	210,555
Series 2006B, MFFA Revenue Bonds	2026	4.00 – 5.00%	54,495	58,170
Series 2006C, WHCFA Revenue Bonds	2033	5.25%	69,425	69,425
Series 2006D, WHCFA Revenue Bonds	2033	5.25%	69,275	69,275
Series 2006E, WHCFA Revenue Bonds	2033	5.25%	26,350	26,350
Series 2006H, AIDEA Revenue Bonds	2036	5.00%	51,905	54,355
Series 2008C, CHFFA Revenue Bonds	2038	3.00 – 6.50%	15,785	17,715
Series 2009A, Direct Obligation Notes	2019	5.05 – 6.25%	165,000	165,000
Series 2009B, CHFFA Revenue Bonds	2039	5.50%	150,000	150,000
Series 2010A, WHCFA Revenue Bonds	2039	4.88 – 5.25%	174,240	174,240
Series 2011A, AIDEA Revenue Bonds	2041	5.00 – 5.50%	122,720	122,720
Series 2011B, WHCFA Revenue Bonds	2021	2.00 – 5.00%	58,995	67,390
Series 2011C, OFA Revenue Bonds	2026	3.50 – 5.00%	18,375	20,405
Series 2012A, WHCFA Revenue Bonds	2042	2.00 – 5.00%	497,850	503,955
Series 2012B, WHCFA Revenue Bonds	2042	4.00 – 5.00%	100,000	100,000
Series 2013A, OFA Revenue Bonds	2024	2.00 – 5.00%	66,600	72,515
Series 2013D, Direct Obligation Notes	2023	4.38%	252,285	252,285
Series 2014A, CHFFA Revenue Bonds	2038	2.00 – 5.00%	274,465	275,850
Series 2014B, CHFFA Revenue Bonds	2044	4.25 – 5.00%	118,740	118,740
Series 2014C, WHCFA Revenue Bonds	2044	4.00 – 5.00%	92,245	92,245
Series 2014D, WHCFA Revenue Bonds	2041	5.00%	178,770	178,770
Series 2015A, WHCFA Revenue Bonds	2045	4.00%	77,635	—
Series 2015C, OFA Revenue Bonds	2045	4.00 – 5.00%	71,070	—
			<u>2,962,605</u>	<u>2,854,980</u>
Variable:				
Series 2012C, WHCFA Revenue Bonds	2042	0.05%	80,000	80,000
Series 2012D, WHCFA Revenue Bonds	2042	0.05%	80,000	80,000
Series 2012E, Direct Obligation Notes	2042	0.17%	233,525	235,705
Series 2013C, OFA Revenue Bonds	2022	1.08%	135,375	148,750
Series 2013E, Direct Obligation Notes	2017	3.00%	200,000	322,250
			<u>728,900</u>	<u>866,705</u>

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

	<u>Maturing through</u>	<u>Coupon rates</u>	<u>Unpaid principal</u>	
			<u>2015</u>	<u>2014</u>
			(In thousands of dollars)	
Commercial Paper, Series 2015B	2016	0.21%	125,000	—
U.S. Bank Credit Facility	2016	0.56%	12,500	12,500
Unpaid principal, master trust debt			3,829,005	3,734,185
Premiums and discounts, net			117,320	123,941
Master trust debt, including premiums and discounts, net			3,946,325	3,858,126
Other long-term debt			165,502	200,923
Total debt			\$ 4,111,827	4,059,049

	<u>2015</u>	<u>2014</u>
	(In thousands of dollars)	
Current portion of long-term debt	\$ 244,532	202,287
Short-term master trust debt	137,500	12,500
Long-term debt, classified as a long-term liability	3,729,795	3,844,262
Total debt	\$ 4,111,827	4,059,049

An Obligated Group was formed for issuing debt under a master trust indenture. Members of the Obligated Group are jointly and severally responsible for all borrowings under the master trust indenture of the Obligated Group. The master trust indenture and bond trust indentures for each debt issue require the Obligated Group to meet certain financial covenants. The members of the Obligated Group include the following:

- Providence Health & Services – Washington (exclusive of Inland Northwest Health Services)
- Western HealthConnect
- Providence Health & Services – Oregon (exclusive of Providence Plan Partners)
- Providence Health System – Southern California (exclusive of Medical Institute of Little Company of Mary, Lifecare Ventures, Inc., TrinityCare Hospice, and Facey)
- Providence St. Joseph Medical Center, and Providence Health & Services – Montana

The Obligated Group excludes related housing projects financed by the U.S. Department of Housing and Urban Development and foundations.

In August and September 2015, the Health System issued \$77,635,000 of Series 2015A WHCFA fixed rate revenue bonds and \$71,070,000 of Series 2015C OFA fixed rate revenue bonds, respectively. The intended use of funds was to cover certain capital investment.

In November 2014, the Health System issued \$178,770,000 of Series 2014D WHCFA fixed rate revenue bonds. The proceeds were used to redeem Series 2006B WHCFA revenue bonds, Series 2006A WHCFA revenue bonds, Series 2010 WHCFA revenue bonds, and Series 2012 WHCFA revenue bonds, which were

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

issued by Kadlec prior to the affiliation. In connection with the Series 2014D issuance, Kadlec became a member of the Obligated Group.

In September 2014, the Health System issued \$92,245,000 of Series 2014C WHCFA fixed rate revenue bonds. The proceeds were used for the partial redemption of Series 2009A PHS Direct Obligation bonds. In connection with the Series 2014C issuance, Swedish Edmonds and PacMed became members of the Obligated Group.

In August 2014, the Health System issued \$118,740,000 of Series 2014B CHFFA fixed rate revenue bonds. The proceeds were used to redeem Series 2013F Commercial Paper, which was issued to finance the purchase of Saint John's. In connection with the Series 2014B issuance, Saint John's became a member of the Obligated Group.

In June 2014, the Health System issued \$275,850,000 of Series 2014A CHFFA fixed rate revenue bonds. The proceeds were used for the partial redemption of Series 2008C CHFFA bonds.

In connection with the Series 2015A-C issuances and the Series 2014A-D issuances, the Health System recorded losses due to extinguishment of debt of \$69,000 and \$85,522,000 in 2015 and 2014, respectively, which were recorded in net nonoperating gains in the accompanying combined statements of operations.

(a) Master Trust Debt Classified as Short-Term

Commercial Paper, Series 2015B

In September 2015, the Health System issued Series 2015B commercial paper obligations. During 2015, the Health System made principal and interest payments on matured commercial paper and reissued new commercial paper, maintaining a balance ranging between \$27,000,000 and \$125,000,000 throughout the year. The average interest rate in effect during 2015 was 0.21%.

U.S. Bank Credit Facility

The Health System has a \$150,000,000 Credit Facility with U.S. Bank, of which \$12,500,000 in borrowings was outstanding at December 31, 2015 and 2014.

(b) Other Long-Term Debt

Other long-term debt primarily includes capital leases, notes payable, and bonds that are not under the master trust indenture. Other long-term debt at December 31, 2015 and 2014 consists of the following:

	<u>2015</u>	<u>2014</u>
	(In thousands of dollars)	
Capital leases	\$ 103,789	114,963
Notes payable	46,988	74,381
Bonds not under master trust indenture and other	<u>14,725</u>	<u>11,579</u>
Total other long-term debt	<u>\$ 165,502</u>	<u>200,923</u>

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

Scheduled principal payments of long-term debt, considering all obligations under the master trust indenture as due according to their long-term amortization schedule, for the next five years and thereafter are as follows:

	<u>Master trust</u>	<u>Other</u>	<u>Total</u>
	(In thousands of dollars)		
2016	\$ 221,535	22,997	244,532
2017	160,175	18,825	179,000
2018	62,960	8,800	71,760
2019	165,895	8,074	173,969
2020	68,830	8,092	76,922
Thereafter	<u>3,012,110</u>	<u>98,714</u>	<u>3,110,824</u>
Scheduled principal payments of long-term debt	3,691,505	\$ <u>165,502</u>	<u>3,857,007</u>
Short-term master trust debt	<u>137,500</u>		
Total master trust debt	\$ <u>3,829,005</u>		

Leases

The Health System leases various medical and office equipment and buildings under operating leases. Future minimum lease commitments under noncancelable operating leases for the next five years and thereafter are as follows (in thousands of dollars):

2016	\$ 124,188
2017	116,588
2018	103,487
2019	94,394
2020	82,802
Thereafter	<u>613,139</u>
	\$ <u>1,134,598</u>

Rental expense was \$216,657,000 and \$193,875,000 for the years ended December 31, 2015 and 2014, respectively, and is included in other expenses in the accompanying combined statements of operations.

(8) Retirement Plans

(a) Defined Benefit Plans

Cash Balance Retirement Plan

The Health System had a noncontributory cash balance plan covering substantially all Providence employees called the Providence Health & Services Cash Balance Retirement Plan Trust (the Cash Balance Plan). The plan was frozen effective December 31, 2009. The plan benefits are based on

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

defined average compensation and years of service. The plan has a five-year cliff vesting schedule. The Health System's funding policy is based on the actuarially determined cost method, and includes normal service cost and prior service costs amortized over a 20-year period. Under the Cash Balance Plan, each employee carries an individual account balance. The Health System makes an annual contribution and provides an annual interest credit to each employee's account.

Supplemental Executive Retirement Plan

The Health System has a noncontributory supplemental executive retirement plan (the SERP) covering certain employees who were employed in certain key positions or pay grades or that have been designated by the Health System. The plan was frozen effective December 31, 2009. The plan benefits were based on defined average compensation and years of service. The vesting period for the plan requires an executive attain age 55 with at least five years of eligible service. The Health System's funding policy is based on the actuarially determined cost method, and includes normal service cost and prior service costs amortized over a 20-year period. Under the SERP, each employee carries an individual account balance. The Health System makes an annual contribution and provides an annual interest credit to each employee's account.

Swedish Health Services Pension Plan

The Swedish Health Services Pension Plan (the Pension Plan) is a noncontributory plan covering a majority of Swedish employees, and provides benefits based on number of years of credited service and compensation earned during the participation in the Pension Plan. The Pension Plan is frozen to all former and existing nonrepresented employees and to all new participants. Only represented employees that were active in the plan on December 31, 2009 remain in the plan actively accruing benefits. The Health System makes annual contributions to the Pension Plan.

Willamette Falls Pension Plan

The Willamette Falls Pension Plan is also a noncontributory plan covering a majority of employees at Providence Willamette Falls. The plan was frozen effective February 2008. The plan benefits are based on years of service and compensation during an employee's period of employment. The funding policy is based on the actuarially determined cost method, and includes normal service cost and prior service costs amortized over a 20-year period. Under the Willamette Falls Pension Plan, each employee carries an individual monthly annuity benefit.

The Cash Balance Plan, the SERP, the Pension Plan, and the Willamette Falls Pension Plan are collectively "the defined benefit plans."

The Health System's contributions to these defined benefit plans for the years ended December 31, 2015 and 2014 were \$90,562,000 and \$100,380,000, respectively.

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

The measurement dates for the defined benefit plans are December 31, 2015 and 2014. A rollforward of the change in benefit obligation and change in the fair value of plan assets for the defined benefit plans is as follows:

	<u>2015</u>	<u>2014</u>
	(In thousands of dollars)	
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	\$ 2,827,325	2,592,617
Service cost	24,858	22,851
Interest cost	113,956	124,911
Actuarial (gain) loss	(134,753)	289,225
Benefits paid and other	<u>(231,159)</u>	<u>(202,279)</u>
Projected benefit obligation at end of year	<u>2,600,227</u>	<u>2,827,325</u>
Change in fair value of plan assets:		
Fair value of plan assets at beginning of year	1,782,250	1,773,628
Actual return on plan assets	(106,400)	110,521
Employer contributions	90,562	100,380
Benefits paid and other	<u>(231,159)</u>	<u>(202,279)</u>
Fair value of plan assets at end of year	<u>1,535,253</u>	<u>1,782,250</u>
Funded status	(1,064,974)	(1,045,075)
Unrecognized net actuarial loss	470,429	441,783
Unrecognized prior service cost	<u>5,068</u>	<u>6,299</u>
Net amount recognized	<u>\$ (589,477)</u>	<u>(596,993)</u>
Amounts recognized in the consolidated balance sheets consist of:		
Current liabilities	\$ (1,393)	(4,136)
Noncurrent liabilities	(1,063,581)	(1,040,939)
Unrestricted net assets	<u>475,497</u>	<u>448,082</u>
Net amount recognized	<u>\$ (589,477)</u>	<u>(596,993)</u>
Weighted average assumptions:		
Discount rate	4.58%	4.20%
Rate of increase in compensation levels	3.50	3.50
Long-term rate of return on assets	6.80	7.00

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

Net periodic pension cost for the defined benefit plans for 2015 and 2014 includes the following components:

	2015	2014
	(In thousands of dollars)	
Components of net periodic pension cost:		
Service cost	\$ 24,858	22,851
Interest cost	113,956	124,911
Expected return on plan assets	(115,711)	(118,676)
Amortization of prior service cost	1,231	1,231
Recognized net actuarial loss	26,163	14,340
Settlement expense	32,549	32,798
Net periodic pension cost	\$ 83,046	77,455

Total expense for all of the Health System's defined benefit plans for the years ended December 31, 2015 and 2014 was \$83,046,000 and \$77,455,000, respectively. Included in the total expense is \$32,549,000 and \$32,798,000 of settlement costs that were incurred in 2015 and 2014, respectively, related to settlements that were greater than the sum of the service cost and interest cost components of net periodic pension cost. This settlement expense is included in net nonoperating gains in the accompanying combined statements of operations. The remaining expense for the defined benefit plans is included in employee benefits in the accompanying combined statements of operations.

The accumulated benefit obligation was \$2,555,741,000 and \$2,771,511,300 at December 31, 2015 and 2014, respectively.

The following pension benefit payments reflect expected future service. Payments expected to be paid over the next 10 years are as follows (in thousands of dollars):

2016	\$ 194,339
2017	176,086
2018	186,764
2019	192,506
2020 – 2025	1,104,643
	\$ 1,854,338

The Health System expects to contribute approximately \$71,600,000 to the defined benefit plans in 2016.

The expected long-term rate of return on plan assets is the expected average rate of return on the funds invested currently and on funds to be invested in the future in order to provide for the benefits included in the projected benefit obligation. The Health System used 6.8% and 7.0% in calculating the 2015 and 2014 expense amounts, respectively. This assumption is based on capital market assumptions and the plan's target asset allocation.

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

The Health System continues to monitor the expected long-term rate of return. If changes in those parameters cause 6.8% to be outside of a reasonable range of expected returns, or if actual plan returns over an extended period of time, suggest that general market assumptions are not representative of expected plan results, the Health System may revise this estimate prospectively.

Target asset allocation and expected long-term rate of return on assets (ELTRA) for the years ended December 31, 2015 and 2014, respectively, were as follows:

	2015 Target	2015 ELTRA	2014 Target	2014 ELTRA
Cash and cash equivalents	2%	1% – 3%	5%	1% – 4%
Equity securities	47	5% – 8%	35	5% – 8%
Debt securities	35	2% – 6%	50	3% – 5%
Other securities	16	5% – 8%	10	6% – 9%
Total	100%	6.80%	100%	7.00%

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

The following table presents the Health System's defined benefit plan assets measured at fair value at December 31, 2015:

	December 31, 2015	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
		(In thousands of dollars)		
Assets:				
Cash and cash equivalents	\$ 38,530	38,530	—	—
Domestic equity securities:				
Mutual funds:				
Large capitalization	16,180	16,180	—	—
Technology	63,668	63,668	—	—
Financial services	52,988	52,988	—	—
Consumer services	48,814	48,814	—	—
Other	96,105	96,105	—	—
Foreign equity securities:				
Mutual funds:				
Large capitalization	14,487	14,487	—	—
Consumer services	14,216	14,216	—	—
Technology	10,693	10,693	—	—
Other	11,983	11,983	—	—
Debt securities – state and government	242,808	169,396	73,412	—
Foreign securities – state and government	7,500	—	7,500	—
Domestic corporate debt securities	115,999	—	115,999	—
Foreign corporate debt securities	15,095	—	15,095	—
Other	7,781	—	7,781	—
Investments measured using NAV	<u>778,406</u>			
Total	<u>\$ 1,535,253</u>			

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

The following table presents the Health System's defined benefit plan assets measured at fair value at December 31, 2014:

	December 31, 2014	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
		(In thousands of dollars)		
Assets:				
Cash and cash equivalents	\$ 44,670	44,670	—	—
Domestic equity securities:				
Mutual funds:				
Medium-small cap and other	2,252	2,252	—	—
Consumer services	184,842	184,842	—	—
Financial services	68,769	68,769	—	—
Technology	45,304	45,304	—	—
Other	62,558	62,558	—	—
Foreign equity securities:				
Mutual funds:				
Large capitalization	44,450	44,450	—	—
Consumer services	15,809	15,809	—	—
Technology	11,777	11,777	—	—
Other	19,809	19,809	—	—
Debt securities – state and government	281,432	208,804	72,628	—
Foreign securities – state and government	14,596	—	14,596	—
Domestic corporate debt securities	129,564	—	129,564	—
Foreign corporate debt securities	22,291	—	22,291	—
Other	13,108	3,246	9,862	—
Investments measured using NAV	821,019			
Total	\$ <u>1,782,250</u>			

The Health System defined benefit plans participate in various funds that are not actively marketed on an open exchange. These investments consist of shares or units in investment funds as opposed to direct interests in the funds' underlying holdings, which may be marketable. Due to the nature of these funds the net asset value per share, or its equivalent, reported by each fund manager is used as a practical expedient to estimate the fair value of the Health System's interest therein. Management believes that the carrying amounts of these financial instruments, provided by the fund managers, are reasonable estimates of fair value.

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

The following table presents information for investments where either the NAV per share or its equivalent was used to value the investments as of December 31:

	Fair value		Redemption frequency	Redemption notice period
	2015	2014		
Hedge funds				
Risk parity	\$ 125,398	138,886	Monthly	5 – 15 days
Growth	142,320	140,305	Quarterly	45 – 90 days
Other	1,444	2,993	Monthly or Quarterly	30 – 90 days
Collective investment funds:				
Equities	355,462	349,662	Monthly	6 – 60 days
Fixed income	153,782	189,173	Daily	3 days
Total	\$ 778,406	821,019		

There were no significant transfers between assets classified as Level 1 and Level 2 during the years ended December 31, 2015 and 2014.

(b) Defined Contribution Plans

401(a) Service Plan

The Health System sponsors the Providence Health & Services 401(a) Service Plan (the Service Plan). The Service Plan covers substantially all Providence employees, with contributions based on defined eligible compensation and years of service. The plan has a five-year cliff vesting schedule. The Health System contributed \$153,563,000 to the Service Plan in 2015 related to prior years, and has accrued a liability of \$161,947,000 as of December 31, 2015 related to contributions to be made in 2016 for plan year 2015. The accrued balance has been included in the current portion of retirement plan obligations on the accompanying combined balance sheets.

403(b) Value Plan

The Health System also sponsors the Providence Health & Services 403(b) Value Plan (the Value Plan). The plan is a defined contribution plan, which includes a qualified cash or deferred arrangement, for the benefit of eligible employees. Vesting is immediate. Total Value Plan expense, primarily related to contributions, was \$77,070,000 and \$74,760,000 in 2015 and 2014, respectively, and is included in employee benefits expense in the accompanying combined statements of operations.

Providence, Swedish, PAML Multiple Employer 401(k) Plan

The Health System sponsors the Providence, Swedish, PAML Multiple Employer 401(k) Plan which covers certain Providence affiliates unable to participate in the Service Plan and the Value Plan. The plan is a defined contribution plan with contributions based on defined eligible compensation. The plan has a four-year cliff vesting schedule. Total plan expense, primarily related to contributions, was \$47,590,000 and \$42,781,000 in 2015 and 2014, respectively, and is included in employee benefits expense in the accompanying combined statements of operations.

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

(9) Self-Insurance Liability

The Health System has established self-insurance programs for professional and general liability and workers' compensation insurance coverage. These programs provide insurance coverage for healthcare institutions associated with the Health System. The Health System also operates an insurance captive, Providence Assurance, Inc., to self-insure or reinsure certain layers of professional and general liability risk.

The Health System accrues estimated self-insured professional and general liability and workers' compensation insurance claims based on management's estimate of the ultimate costs for both reported claims and actuarially determined estimates of claims incurred-but-not-reported. Insurance coverage in excess of the per occurrence self-insured retention, has been secured with insurers or reinsurers for specified amounts for professional, general, and workers' compensation liabilities. Decisions relating to the limit and scope of the self-insured layer and the amounts of excess insurance purchased are reviewed each year, subject to management's analysis of actuarial loss projections and the price and availability of acceptable commercial insurance.

At December 31, 2015 and 2014, the estimated liability for future costs of professional and general liability claims was \$249,013,000 and \$232,639,000, respectively. At December 31, 2015 and 2014, the estimated workers' compensation obligation was \$162,728,000 and \$150,845,000, respectively, in the accompanying combined balance sheets. At December 31, 2015 and 2014, \$292,843,000 and \$274,541,000, respectively, of these amounts were included as self-insurance liability, net of current portion, with the remainder included within current portion of self-insurance liability, in the accompanying combined balance sheets.

(10) Commitments

Firm purchase commitments, primarily related to construction, software, and supplies, at December 31, 2015, are approximately \$163,590,000.

(11) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at December 31, 2015 and 2014:

	<u>2015</u>	<u>2014</u>
	(In thousands of dollars)	
Program support	\$ 184,340	160,842
Low-income housing	32,950	34,036
Capital acquisition and other	<u>107,601</u>	<u>110,399</u>
Total temporarily restricted net assets	<u>\$ 324,891</u>	<u>305,277</u>

The Health System's fundraising foundations have obtained contributions to support the various programs offered by the Health System. Many of these contributions remain temporarily restricted as of December 31, 2015 and 2014 because the time or purpose restrictions stipulated by the donor have not been met. Generally, program support consists of items that will defray the cost of operating certain patient care activities of the Health System.

PROVIDENCE HEALTH & SERVICES

Notes to Combined Financial Statements

December 31, 2015 and 2014

Other revenues included \$48,228,000 and \$48,589,000 of assets released from restriction for operations for the years ended December 31, 2015 and 2014, respectively.

Permanently restricted net assets are restricted to investments in perpetuity, the income of which is expendable primarily for program support.

(12) Litigation and Contingencies

The healthcare industry is subject to numerous laws and regulations from federal, state, and local governments. Compliance with these laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time. Government monitoring and enforcement activity continues with respect to investigations and allegations concerning possible violations by healthcare providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of patient services previously billed. Institutions within the Health System are subject to similar regulatory reviews.

Management is aware of certain asserted and unasserted legal claims and regulatory matters arising in the course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Health System's combined financial statements.

(13) Functional Expenses

The Health System provides healthcare services to residents within its geographic service areas. Expenses related to providing these services for the years ended December 31, 2015 and 2014 are as follows:

	<u>2015</u>	<u>2014</u>
	(In thousands of dollars)	
Healthcare expenses	\$ 10,700,175	9,199,881
Purchased healthcare expenses	1,045,019	909,154
General and administrative expenses	<u>2,426,771</u>	<u>2,152,790</u>
Total operating expenses	<u>\$ 14,171,965</u>	<u>12,261,825</u>

PROVIDENCE HEALTH & SERVICES
Supplemental Schedule – Balance Sheet Information
December 31, 2015 (with combined totals for 2014)
(In thousands of dollars)

Assets	Alaska	Washington	Montana	Oregon	Providence Plan Partners	Southern California	System office, eliminations, and other	2015 Total Health System	2014 Total Health System
Current assets:									
Cash and cash equivalents	\$ 213,952	191,084	7,779	207,553	74,695	(113,363)	147,621	729,321	1,237,337
Short-term management-designated investments	—	—	—	—	—	18,721	181,530	200,251	199,338
Accounts receivable, net	160,005	815,096	51,729	319,025	—	298,333	(74,361)	1,569,827	1,419,495
Other receivables, net	20,088	939,747	82,816	98,241	53,994	109,741	(905,336)	399,291	375,185
Supplies inventory	12,605	85,491	5,991	37,507	—	28,461	24,564	194,619	185,821
Other current assets	1,090	33,651	247	22,443	3,803	24,030	55,572	140,836	203,337
Current portion of funds held by trustee	76	2,672	1	1,478	—	64	50,449	54,740	76,365
Total current assets	407,816	2,067,741	148,563	686,247	132,492	365,987	(519,961)	3,288,885	3,696,878
Assets whose use is limited:									
Management-designated cash and investments	523,467	1,350,622	47,682	1,204,626	570,946	218,945	1,014,570	4,930,858	4,601,153
Gift annuities, trusts, and other	360	16,366	2,351	27,886	—	15,116	31,725	93,804	53,954
Funds held by trustee	—	66,617	—	68,371	15,793	350	121,771	272,902	179,473
Assets whose use is limited, net	523,827	1,433,605	50,033	1,300,883	586,739	234,411	1,168,066	5,297,564	4,834,580
Property, plant, and equipment, net	552,020	3,065,950	94,018	1,030,286	69,003	1,025,488	744,095	6,580,860	6,622,566
Other assets	26,746	241,655	21,127	61,618	1,381	230,317	(9,876)	572,968	568,884
Total assets	\$ 1,510,409	6,808,951	313,741	3,079,034	789,615	1,856,203	1,382,324	15,740,277	15,722,908
Liabilities and Net Assets									
Current liabilities:									
Current portion of long-term debt	\$ 26,748	99,844	4,179	40,312	—	30,569	42,880	244,532	202,287
Master trust debt classified as short-term	—	—	—	—	—	—	137,500	137,500	12,500
Accounts payable	14,237	198,078	12,596	58,642	1,657	100,033	42,324	427,567	521,942
Accrued compensation	24,888	224,403	10,118	108,782	—	71,063	202,152	641,406	738,075
Payable to contractual agencies	5,742	51,047	122	3,812	2,952	8,168	32,808	104,651	151,778
Retirement plan obligations	—	—	—	—	—	—	190,278	190,278	185,517
Current portion of self-insurance liability	—	10,802	—	—	—	—	108,096	118,898	108,943
Other current liabilities	4,833	1,068,887	79,540	94,507	288,701	119,630	(1,192,900)	463,198	465,865
Total current liabilities	76,448	1,653,061	106,555	306,055	293,310	329,463	(436,862)	2,328,030	2,386,907
Long-term debt, net of current portion (1)	253,626	2,164,345	52,037	292,987	—	671,023	295,777	3,729,795	3,844,262
Other long-term liabilities	21,773	454,702	6,380	45,460	1,382	65,524	1,051,583	1,646,804	1,542,579
Total liabilities	351,847	4,272,108	164,972	644,502	294,692	1,066,010	910,498	7,704,629	7,773,748
Net assets:									
Unrestricted	1,145,988	2,409,856	142,933	2,326,791	494,923	639,972	426,316	7,586,779	7,537,626
Temporarily restricted	9,668	91,567	3,973	71,771	—	110,599	37,313	324,891	305,277
Permanently restricted	2,906	35,420	1,863	35,970	—	39,622	8,197	123,978	106,257
Total net assets	1,158,562	2,536,843	148,769	2,434,532	494,923	790,193	471,826	8,035,648	7,949,160
Total liabilities and net assets	\$ 1,510,409	6,808,951	313,741	3,079,034	789,615	1,856,203	1,382,324	15,740,277	15,722,908

(1) The Obligated Group debt is joint and several for the Obligated Group members, however, the balance sheets of the individual entities only include their allocated portions.

See accompanying independent auditors' report.

PROVIDENCE HEALTH & SERVICES
Supplemental Schedule – Statement of Operations Information
December 31, 2015 (with combined totals for 2014)
(In thousands of dollars)

	Alaska	Washington	Montana	Oregon	Providence Plan Partners	Southern California	System office, eliminations, and other	2015 Total Health System	2014 Total Health System
Operating revenues:									
Net patient service revenues	\$ 836,680	6,218,533	352,193	2,778,202	—	2,302,762	(519,254)	11,969,116	10,294,637
Provision for bad debts	(24,946)	(77,864)	(5,092)	(6,163)	—	(67,149)	(4,353)	(185,567)	(193,018)
Net patient service revenues less provision for bad debts	811,734	6,140,669	347,101	2,772,039	—	2,235,613	(523,607)	11,783,549	10,101,619
Premium and capitation revenues	—	181,793	—	96,362	1,330,926	253,155	—	1,862,236	1,682,968
Other revenues	51,996	314,105	26,771	263,283	79,623	113,959	(61,741)	787,996	696,390
Total operating revenues	863,730	6,636,567	373,872	3,131,684	1,410,549	2,602,727	(585,348)	14,433,781	12,480,977
Operating expenses:									
Salaries and wages	270,356	2,648,830	120,575	1,199,743	2,920	885,997	855,298	5,983,719	5,248,196
Employee benefits	24,395	368,935	10,693	117,004	17	80,075	756,584	1,357,703	1,220,078
Purchased healthcare	—	90,852	—	30,800	1,270,029	97,412	(444,074)	1,045,019	909,154
Professional fees	19,041	159,648	17,401	74,346	25,505	240,384	45,775	582,600	514,990
Supplies	111,607	1,015,985	73,416	518,569	659	318,183	33,586	2,072,005	1,792,707
Purchased services	53,791	407,247	38,484	154,627	146,166	166,111	138,763	1,105,189	977,247
Depreciation	54,600	263,881	11,263	107,851	2,098	70,778	120,066	630,537	676,357
Interest	14,725	86,479	2,689	5,994	—	32,617	10,976	153,480	155,343
Amortization	(12)	(1,045)	438	(325)	—	746	918	720	5,671
Other	24,528	498,491	14,186	194,265	38,759	293,719	177,045	1,240,993	702,082
Total operating expenses	573,031	5,539,303	289,145	2,402,874	1,486,153	2,186,522	1,694,937	14,171,965	12,261,825
Excess (deficit) of revenues over expenses from operations	290,699	1,097,264	84,727	728,810	(75,604)	416,205	(2,280,285)	261,816	219,152
Net nonoperating (losses) gains	(4,485)	(45,752)	226	(28,337)	7,855	(17,580)	(96,918)	(184,991)	552,270
Excess (deficit) of revenues over expenses	286,214	1,051,512	84,953	700,473	(67,749)	398,625	(2,377,203)	76,825	771,422
Net assets released from restriction for capital	109	7,027	(92)	2,618	—	9,622	1,088	20,372	13,646
Change in noncontrolling interests in consolidated joint ventures	(73)	(397)	—	(804)	—	(819)	1,695	(398)	584
Pension related changes	—	(19,156)	—	1,263	—	—	(9,522)	(27,415)	(249,011)
Interdivision transfers	(171,911)	(954,602)	(79,776)	(685,019)	—	(480,719)	2,372,027	—	—
Contributions, grants, and other	(3,497)	(8,491)	10	(2,769)	—	(4,073)	(1,411)	(20,231)	(8,639)
Increase (decrease) in unrestricted net assets	\$ 110,842	75,893	5,095	15,762	(67,749)	(77,364)	(13,326)	49,153	528,002

See accompanying independent auditors' report.

Management's Discussion and Analysis of Financial Condition and Results of Operations

Year ended December 31, 2016

About Providence St. Joseph Health

Effective July 1, 2016, Providence Health & Services and St. Joseph Health came together to serve more people in a partnership that joins two remarkable organizations with rich heritages. We are now connected by a new parent organization, Providence St. Joseph Health. Together, over 100,000 of our caregivers (employees) now serve in 50 hospitals, over 800 clinics and a comprehensive range of health and social services across Alaska, California, Montana, New Mexico, Oregon, Texas and Washington. All hospitals and other ministries will maintain their current names and identities. This parent structure allows our family of diverse organizations to work together to meet the needs of our communities both today and into the future.

Providence Health & Services
Alaska



Providence Health & Services

Western Washington, including Swedish Health Services and Pacific Medical Centers



Providence Health & Services
Eastern Washington/Western Montana, including Kadlec Regional Medical Center

Providence Health & Services
Oregon



St. Joseph Health
Northern California (Humboldt, Napa, Sonoma Counties) including St. Joseph Heritage Healthcare

Providence Health & Services
Southern California (Los Angeles County), including Facey Medical Foundation

St. Joseph Health
Southern California (Orange and San Bernardino Counties) including Hoag Health and St. Joseph Heritage Healthcare



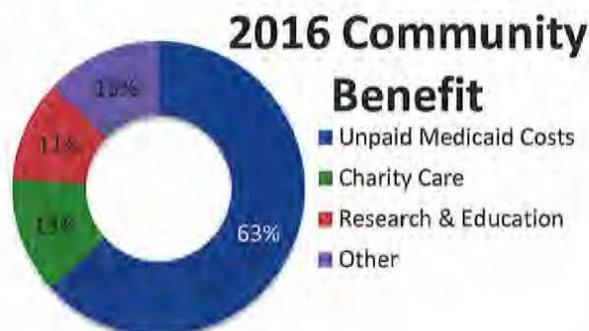
St. Joseph Health
West Texas/Eastern New Mexico, including Covenant Health and Covenant Medical Group



Investing in our communities to improve health and increase access

Providence St. Joseph Health provided \$1.6 billion in community benefit in 2016. Through programs and donations, health education, free care, medical research and more, our community benefit investments fulfill unmet needs in communities we serve across seven states.

In an environment of decreased reimbursement for government-sponsored medical care, community benefit spending related to the unpaid costs of Medicaid was more than \$1 billion through the fourth quarter of 2016. Answering the call of our Mission to care for everyone, regardless of their ability to pay, we offered more than \$210 million in free and discounted care for those in need.



Advocating for important health and social programs

We believe health care is a basic human right and are committed to expanded coverage that gives access to affordable care for all. With a special focus on serving those who are poor and vulnerable, we advocate for policies that will improve the health of entire communities and further facilitate innovation in care and payment models. During 2016 we helped advance legislation that supports primary care, care management and cognitive services, telehealth services and new care and payment models in Medicaid and Medicare.

Our commitment to mental health

In honor of the 143,000 caregivers, physicians, volunteers and board members who make up Providence St. Joseph Health, the System donated \$1.43 million to organizations focused on improving awareness and care for those with mental illness. Donations were made to the Mental Health First Aid program, sponsored by the National Council for Behavioral Health, and the National Alliance on Mental Illness Family-to-Family program. The funds will support the training of more than 50,000 people living and working in Providence St. Joseph Health communities on skills such as understanding the signs of mental illness.

We also announced the Institute for Mental Health and Wellness' first chief executive, Tyler Norris, MDiv. The institute was founded as part of a larger commitment by Providence St. Joseph Health to address the growing mental health crisis in the U.S. The System made an initial seed endowment of \$100 million to support advances in behavioral health, including awareness, diagnosis and treatment. In his new role, Norris will shape the institute's vision and strategic direction through community-based collaborations and partnerships.

Leading dynamic change through innovation

Extending relationships between episodes of care

Providence St. Joseph Health's Digital and Innovation Division aims to build meaningful relationships and serve as valuable partners in health. The group tests consumer innovations that are adjacent to our health care services and improve overall community health. Through these innovations, we decrease our population risk by creating a continuous relationship with consumers between episodes of care.

We are currently running new services in women's health (Circle™) and senior services (Optimal Aging™). The Circle™ women and children's app is built on a personalization platform which provides trusted answers to frequently asked questions about maternal and pediatric health. This service enables families to connect to the System and community resources conveniently, and is deploying across the System in 2017. Optimal Aging™ provides seniors affordable access to transportation, meals, home care, home maintenance and social connections. This service fulfills goals to support seniors' day-to-day living, improve the safety of their homes, and provide trusted planning and advice about aging optimally. Optimal Aging™ is currently available in King and Snohomish counties, Wash., and looks forward to expanding to Portland, Ore. in 2017.

Introduction to Management's Discussion and Analysis

Management's discussion and analysis provides additional narrative explanation of the financial condition, operational results and cash flow of the System to increase understanding of the combined financial statements. The following information should be read in conjunction with the audited combined financial statements and related footnotes.

System overview

Effective July 1, 2016, Providence St. Joseph Health, a Washington nonprofit corporation, became the sole member of both Providence Health & Services, a Washington nonprofit corporation, and St. Joseph Health, a California nonprofit public benefit corporation, each of which were a multi-state health system, creating one of the largest health care systems in the United States. The System, headquartered in Renton, Washington, is structured with a centralized operating model and governed by a co-sponsorship council made up of members of its two sponsoring ministries, Providence Ministries and St. Joseph Health Ministry.

Providence Health & Services has a fiscal year ending December 31, and St. Joseph Health has a fiscal year ending June 30. The System has adopted a fiscal year ending December 31. To enable certain financial results to be presented on a consistent basis, notwithstanding the difference in fiscal years, unaudited pro forma combined financial results of the System are presented for the twelve-month periods ended December 31, 2016 and 2015.

Financial performance

The results discussed in this document are presented on a pro forma basis for the System. Data was derived by combining the consolidated year-to-date results of Providence Health & Services and St. Joseph Health assuming that operations of the two organizations were combined as of January 1, 2015. Certain immaterial adjustments have been made to conform financial statement presentations. Pro forma data includes the impact of affiliation related transactions, such as asset write-ups and the related amortization/depreciation of these assets, prior to the affiliation date of July 1, 2016. Management believes this pro forma data is the most useful presentation for evaluating and discussing current year operations in comparison to the prior year.

Year-to-date results

Balance Sheet PRESENTED IN MILLIONS	Providence St. Joseph Health (Pro Forma)			
	12-31-16	12-31-2015	12 MONTH CHANGE	CHANGE %
<u>Current Assets:</u>				
Cash and Cash Equivalents	782	885	(103)	(12%)
Short-term Management Designated Investments	875	1,139	(264)	(23%)
Accounts Receivable, Net	2,206	2,153	53	2%
Other Current Assets	1,449	1,047	402	38%
Current Portion of Funds Held by Trustee	109	55	54	98%
Total Current Assets	5,421	5,279	142	3%
<u>Assets Whose Use is Limited:</u>				
Management Designated Cash and Investments	8,091	7,361	730	10%
Funds Held by Trustee, Gift, Annuity, and Other	641	512	129	25%
Total Assets Whose Use is Limited	8,731	7,873	858	11%
Property, Plant & Equipment	11,022	10,477	545	5%
Total Other Assets	1,118	1,220	(102)	(8%)
Total Assets	26,292	24,849	1,443	6%
<u>Current Liabilities:</u>				
Short-term Debt and Current Portion of Long-term Debt	353	471	(118)	(25%)
Accounts Payable	584	555	29	5%
Accrued Compensation	1,104	924	180	19%
Other Current Liabilities	1,911	1,446	465	32%
Total Current Liabilities	3,952	3,396	556	16%
Long-Term Debt, Net of Current Portion	6,396	6,009	387	6%
Other Long-term Liabilities	2,149	2,039	110	5%
Total Liabilities	12,497	11,444	1,053	9%
<u>Net Assets:</u>				
Unrestricted	12,759	12,539	220	2%
Restricted Net Assets	1,035	866	169	20%
Total Net Assets	13,795	13,405	390	3%
Total Liabilities and Net Assets	26,292	24,849	1,443	6%

Statement of Operations DATA PRESENTED YEAR TO DATE; \$ FIGURES PRESENTED IN MILLIONS	Providence St. Joseph Health (Pro Forma)			
	2016 ACTUAL	2015 ACTUAL	VARIANCE	VARIANCE %
Net Patient Revenue	17,296	16,575	721	4%
Premium and Capitation Revenue	3,773	3,116	657	21%
Other Revenue	1,088	1,050	38	4%
Total Revenue	22,157	20,741	1,416	7%
Salaries and Wages	8,926	8,145	781	10%
Depreciation	1,036	997	39	4%
Interest and Amortization	265	260	5	2%
Other Expenses	12,185	11,058	1,127	10%
Total Operating Expenses	22,412	20,460	1,952	10%
Excess of Revenues Over Expenses from Operations	(255)	281	(536)	(191%)
Net Nonoperating Gains (Losses)	5,485	(248)	5,733	(2312%)
Excess of Revenues Over Expenses	5,230	33	5,197	15748%
Operating EBIDA	1,046	1,537	(491)	(32%)

Key Financial Indicators DATA PRESENTED YEAR TO DATE; \$ FIGURES PRESENTED IN MILLIONS	Providence St. Joseph Health (Pro Forma)			
	2016 ACTUAL	2015 ACTUAL	YTD VAR	YTD VAR %
Operating Margin %	(1.2)	1.4	(2.6)	(186%)
Operating EBIDA Margin %	4.7	7.4	(2.7)	(36%)
Total Community Benefit	1,632	1,445	187	13%
Net Service Revenue / Case Mix Adj Admits (whole value)	11,817	12,118	(301)	(2%)
Expense/ Case Mix Adj Admits	11,976	11,932	44	0%
FTEs (presented in thousands)	102	96	6	6%

Lower reimbursement for services from changes in payor mix, payment rates and procedure mix remains the most significant challenge for the System. While volumes have continued to grow in comparison to the prior year, this growth has correlated with a higher percentage of Medicaid patients and increases in acuity levels as measured by case mix index. In addition to reimbursement challenges, the System has been facing increasing labor and supply costs. A competitive labor market has led to higher wage costs and increased vacancy, resulting in greater utilization and rates of agency staffing. These industry challenges have exerted financial pressure on the System, resulting in a year-to-date operating loss of \$255 million.

Net income included a net gain of \$5.1 billion in 2016 from the affiliation inherent contribution and one-time debt refinancing, which was primarily driven by the St. Joseph Health affiliation and subsequent debt restructuring. The inherent contribution is the result of the affiliation being a non-cash transaction. With the impact of the affiliation inherent contribution and debt refinancing removed, year-to-date net income was \$122 million, up from \$33 million in the prior year. The increase in adjusted net income was primarily the result of current year investment gains of \$493 million, partially offset by operating losses and innovation related expenses.

Volumes

Key Volume Indicators DATA PRESENTED YEAR TO DATE; IN THOUSANDS UNLESS NOTED	Providence St. Joseph Health (Pro Forma)			
	2016 ACTUAL	2015 ACTUAL	YTD VAR	YTD VAR %
Inpatient Admissions	526	519	7	1%
Acute Adjusted Admissions	989	957	32	3%
Outpatient Visits	24,352	22,875	1,477	6%
Total Surgeries	567	545	22	4%
Providence Health Plan Members	639	513	126	25%

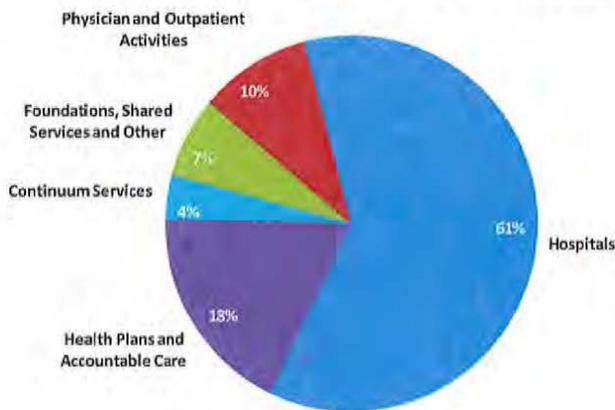
While the System has experienced volumes growth in 2016, trends in this growth have been highly influenced by the effects of the Affordable Care Act. Specifically, growth has been highest amongst Medicaid patients with an overall higher acuity level, which require additional resources to serve. Additionally, the System has experienced increases in ambulatory services at a rate that largely outpaced growth in acute and inpatient services. This increase in physician visits was attributed to employment of new physicians and advanced care practitioners in 2016, in addition to increased panel sizes for clinicians hired in 2015. Clinic expansion also continued through our partnership with Walgreens, opening 25 new clinics in 2016.

Surgery volumes also experienced higher growth in the outpatient setting as compared to the inpatient setting. Year-to-date inpatient surgeries increased 1 percent, while outpatient increased 6 percent as compared to the same period of 2015. Surgery increases are partially attributed to an exclusive contract with Group Health in Washington to provide inpatient services as well as improvements in integrated care networks.

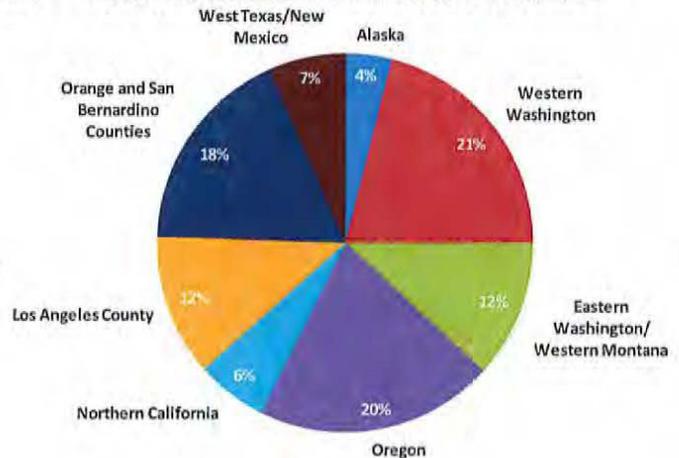
The Providence Health Plan enrollment growth has continued in 2016 through an expansion of services and coverage. Year-to-date connected lives member months, a measure of coverage for insured members, increased from 6.1 million member months in 2015 to 7.5 million member months in 2016.

Operating Revenue

2016 NET OPERATING REVENUE BY LINE OF BUSINESS



2016 NET OPERATING REVENUE BY MARKET



Year-to-date operating revenue of \$22.2 billion was 7 percent greater than the prior year. Approximately half of the increase was driven by a 21 percent rise in capitated and premium revenue. Total premium revenue of \$2.8 billion was 41 percent higher than prior year as health plan member enrollment increased in 2016. Premium revenue grew at a slower rate than membership as a result of changes in business line mix. Capitated and premium revenue now represents 17 percent of the System's total operating revenue as compared to 15 percent in the prior year.

Patient service revenue grew by 4 percent which was less than the 6 percent volume increase as measured by case mix adjusted admissions. The lower service revenue growth was driven by changes in payor mix, payment rates and procedure mix. While higher acuity as measured by case mix index generally results in higher reimbursement, related increases in revenue were offset by unfavorable shifts in payor mix. Medicaid and Medicare revenues as a percentage of total net revenue grew by 1 percent to become 48 percent of the acute business.

Payor Mix -Net Patient Revenue	Providence St. Joseph Health (Pro Forma)			
	2016 ACTUAL	2015 ACTUAL	YTD VAR	YTD VAR %
Commercial	51%	51%	0%	0%
Medicare	32%	31%	1%	3%
Medicaid	16%	16%	0%	0%
Self-pay	2%	1%	1%	100%
Other	(1%)	1%	(2%)	0%

Operating expenses

Year-to-date operating expenses grew by 10 percent over the prior year as a result of the costs from higher volumes, patient acuity levels, and rates to serve those volumes. Expenses from labor and supplies grew at a higher rate than volumes due to inflation and productivity deterioration, while the increase in purchased health care services correlated with higher health plan member enrollment. Year-to-date salaries and benefits grew by 7 percent over prior year. This unfavorable trend was driven by full-time equivalent (FTE) growth of 6 percent and rate growth of 3 percent from a competitive labor market.

Supply expense as a percentage of net service revenue is 6 percent higher than the prior year, representing a \$299 million increase. This increase was primarily driven by growth of specialty, retail, ambulatory, and infusion center pharmacy costs. Overall supply costs have increased 10 percent over the prior year, primarily driven by pharmacy costs that have increased 14 percent over the same period.

Year-to-date purchased healthcare expenses were 51 percent higher than the prior year as a result of growth in enrolled members of the Providence Health Plan over the prior year.

Non-Operating Income

Non-operating income included a net gain of \$5.1 billion in 2016 from the affiliation inherent contribution and one-time debt refinancing, which was primarily driven by the St. Joseph Health affiliation and subsequent debt restructuring. With the impact of the affiliation inherent contribution and debt refinancing removed, year-to-date non-operating gains were \$377 million. This amount was driven by year-to-date

investment gains of \$493 million in 2016, compared to year-to-date losses of \$156 million in 2015. Investment income was partially offset by growth in other non-operating expenses such as pension settlement costs and innovation investments, which were \$28 million and \$44 million through December, respectively.

Capital and liquidity

Liquidity Indicators DATA PRESENTED YEAR TO DATE, \$ FIGURES PRESENTED IN MILLIONS	Providence St. Joseph Health (Pro Forma)			
	12-31-16 ACTUAL	12-31-15 ACTUAL	YTD VAR	YTD VAR %
Accounts Receivable Days	45	46	(1)	(2%)
Days of Cash on Hand	168	177	(9)	(5%)
Long-term Debt to Capitalization	33.9	32.9	1.0	3%
Debt Service Coverage	1.8	3.2	(1.4)	(44%)
Cash to Debt Ratio	148.8	152.7	(3.9)	(3%)
Cash to Total Net Asset Ratio	0.76	0.75	0.01	1%

Unrestricted cash reserves totaled \$9.7 billion as of December 31, 2016, up from \$9.2 billion as of December 31, 2015. The increase was driven by cash generated from operations, investment gains and proceeds from financing transactions, partially offset by payments related to pension obligations, debt, and capital expenditures. Despite cash growth from prior year, higher costs associated with servicing additional volumes resulted in an overall four day decline in days of cash on hand.

In the third quarter of 2016, the System initiated a series of bond offerings which included the refinancing of certain tax-exempt bonds held by St. Joseph Health prior to the affiliation, executing on a plan to create a single obligated group. The aggregate offering included \$448 million of California tax-exempt fixed rate bonds, \$286 million of California tax-exempt fixed rate put bonds, \$680 million of taxable fixed rate bonds, \$100 million of taxable variable rate bonds and a few privately placed direct purchases with staggered tender dates. The offering unified the debt structures of the System at a more favorable cost of capital. While retirement of the existing debt resulted in \$60 million in one-time losses on extinguishment of debt, the overall transaction will generate more than \$25 million in annual interest savings.

Prior to the debt offering but subsequent to the affiliation of Providence Health & Services and St. Joseph Health, the three national credit rating agencies conducted their annual review process of the newly formed Providence St. Joseph Health. The agencies issued the following credit ratings:

- Fitch: "AA-"
- Standard and Poor's: "AA-"
- Moody's: "Aa3"

All three agencies issued a stable outlook based on the System's favorable enterprise profile and strong financial position. As further evidence of the System's financial strength, the recent bond offering demonstrated ample demand throughout the pricing process from investors.

Subsequent Events

Effective February 23, 2017 the Health System and Catholic Health Initiatives entered into an agreement with Laboratory Corporation of America to sell all of its ownership interest in Pathology Associates Medical Laboratories and its affiliated joint ventures.

In October 2016 Providence St. Joseph Health reached a tentative settlement to resolve an outstanding law suit regarding the Church Plan designation of the Providence Cash Balance Retirement Plan (the Plan). Terms of the settlement included a commitment to contribute \$350M over a seven year period and payment of up to \$6.5M in plaintiff attorney fees. As a condition of the settlement the Health System will retain the Church Plan designation of the Plan. The settlement is in the process of court approval and class notification. If approved, the settlement will not have a material adverse effect on financial condition of Providence St. Joseph Health.

The System versus St. Joseph Health financial performance crosswalk

As noted previously, the results discussed in this document are presented on a pro forma basis for the System. The tables below represent a comparison of the combined pro forma data for 2016 and 2015 versus audited results of the System, which includes St. Joseph Health financial results from the effective date of the affiliation of July 1, 2016.

Statement of Operations DATA PRESENTED YEAR TO DATE; \$ FIGURES PRESENTED IN MILLIONS	2016	
	Providence St. Joseph Health (Pro Forma)	Providence St. Joseph Health Audited Results
Net Patient Revenue	17,296	14,769
Premium and Capitation Revenue	3,773	3,104
Other Revenue	1,088	1,005
Total Revenue	22,157	18,878
Salaries and Wages	8,926	7,788
Depreciation	1,036	851
Interest and Amortization	265	215
Other Expenses	12,185	10,274
Total Operating Expenses	22,412	19,128
Excess of Revenues Over Expenses from Operations	(255)	(250)
Net Nonoperating Gains (Losses)	5,485	5,480
Excess of Revenues Over Expenses	5,230	5,230

Statement of Operations DATA PRESENTED YEAR TO DATE; \$ FIGURES PRESENTED IN MILLIONS	2015	
	Providence St. Joseph Health (Pro Forma)	Providence St. Joseph Health Audited Results
Net Patient Revenue	16,575	11,784
Premium and Capitation Revenue	3,116	1,862
Other Revenue	1,050	788
Total Revenue	20,741	14,434
Salaries and Wages	8,145	5,984
Depreciation	997	631
Interest and Amortization	260	154
Other Expenses	11,058	7,403
Total Operating Expenses	20,460	14,172
Excess of Revenues Over Expenses from Operations	281	262
Net Nonoperating Gains (Losses)	(248)	(185)
Excess of Revenues Over Expenses	33	77



PROVIDENCE ST. JOSEPH HEALTH
Combined Financial Statements
December 31, 2016 and 2015
(With Independent Auditors' Report Thereon)



KPMG LLP
Suite 2900
1918 Eighth Avenue
Seattle, WA 98101

Independent Auditors' Report

The Board of Directors
Providence St. Joseph Health:

We have audited the accompanying combined financial statements of Providence St. Joseph Health, which comprise the combined balance sheets as of December 31, 2016 and 2015, and the related combined statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditors consider internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the financial position of Providence St. Joseph Health as of December 31, 2016 and 2015, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP

Seattle, Washington
March 22, 2017

PROVIDENCE ST. JOSEPH HEALTH

Combined Balance Sheets

December 31, 2016 and 2015

(In millions of dollars)

Assets	2016	2015
Current assets:		
Cash and cash equivalents	\$ 1,000	729
Accounts receivable, less allowance for bad debts of \$271 in 2016 and \$344 in 2015	2,206	1,570
Supplies inventory	279	195
Other current assets	1,169	540
Current portion of assets whose use is limited	766	256
Total current assets	5,420	3,290
Assets whose use is limited	8,731	5,298
Property, plant, and equipment, net	11,022	6,581
Other assets	1,118	540
Total assets	\$ 26,291	15,709
Current liabilities:		
Current portion of long-term debt	\$ 200	245
Master trust debt classified as short-term	153	138
Accounts payable	584	428
Accrued compensation	1,104	641
Other current liabilities	1,911	878
Total current liabilities	3,952	2,330
Long-term debt, net of current portion	6,396	3,696
Pension benefit obligation	1,120	1,064
Other liabilities	1,027	583
Total liabilities	12,495	7,673
Net assets:		
Unrestricted:		
Controlling interest	12,560	7,542
Noncontrolling interest	200	45
Temporarily restricted	816	325
Permanently restricted	220	124
Total net assets	13,796	8,036
Total liabilities and net assets	\$ 26,291	15,709

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH
 Combined Statements of Operations
 Years ended December 31, 2016 and 2015
 (In millions of dollars)

	2016	2015
Operating revenues:		
Net patient service revenues	\$ 14,972	11,969
Provision for bad debts	(203)	(186)
Net patient service revenues less provision for bad debts	14,769	11,783
Premium revenues	2,240	1,464
Capitation revenues	865	399
Other revenues	1,005	788
Total operating revenues	18,879	14,434
Operating expenses:		
Salaries and benefits	9,599	7,341
Supplies	2,788	2,072
Purchased healthcare services	1,917	1,045
Interest, depreciation, and amortization	1,066	785
Purchased services, professional fees, and other	3,758	2,929
Total operating expenses	19,128	14,172
(Deficit) excess of revenues over expenses from operations	(249)	262
Net nonoperating gains (losses):		
Contributions from affiliations	5,167	—
Loss on extinguishment of debt	(60)	—
Investment income (losses), net	403	(114)
Other	(30)	(71)
Total net nonoperating gains (losses)	5,480	(185)
Excess of revenues over expenses	\$ 5,231	77

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH
 Combined Statements of Changes in Net Assets
 Years ended December 31, 2016 and 2015
 (In millions of dollars)

	Unrestricted: controlling interest	Unrestricted: noncontrolling interest	Temporarily restricted	Permanently restricted	Total net assets
Balance, December 31, 2014	\$ 7,492	45	305	106	7,948
Excess of revenues over expenses	72	5	—	—	77
Contributions, grants, and other	(15)	(5)	89	18	87
Net assets released from restriction	20	—	(69)	—	(49)
Pension related changes	(27)	—	—	—	(27)
Increase in net assets	<u>50</u>	<u>—</u>	<u>20</u>	<u>18</u>	<u>88</u>
Balance, December 31, 2015	<u>7,542</u>	<u>45</u>	<u>325</u>	<u>124</u>	<u>8,036</u>
Excess of revenues over expenses	5,093	138	—	—	5,231
Restricted contributions from affiliations	—	—	405	91	496
Contributions, grants, and other	(13)	17	145	5	154
Net assets released from restriction	19	—	(59)	—	(40)
Pension related changes	(81)	—	—	—	(81)
Increase in net assets	<u>5,018</u>	<u>155</u>	<u>491</u>	<u>96</u>	<u>5,760</u>
Balance, December 31, 2016	<u>\$ 12,560</u>	<u>200</u>	<u>816</u>	<u>220</u>	<u>13,796</u>

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH
 Combined Statements of Cash Flows
 Years ended December 31, 2016 and 2015
 (In millions of dollars)

	2016	2015
Cash flows from operating activities:		
Increase in net assets	\$ 5,760	88
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Contributions from affiliations	(5,663)	—
Depreciation and amortization	860	631
Provision for bad debt	203	186
Loss on extinguishment of debt	60	—
Restricted contributions and investment income received	(150)	(113)
Net realized and unrealized (gains) losses on investments	(316)	179
Changes in certain current assets and current liabilities	13	(485)
Change in certain long-term assets and liabilities	26	111
Net cash provided by operating activities	793	597
Cash flows from investing activities:		
Property, plant, and equipment additions	(967)	(637)
Sales (purchases) of trading securities, net	68	(242)
Purchases of alternative investments and commingled funds	(466)	(360)
Proceeds from sales of alternative investments and commingled funds	153	44
Cash acquired through affiliations	367	—
Other investing activities	49	(77)
Net cash used in investing activities	(796)	(1,272)
Cash flows from financing activities:		
Proceeds from restricted contributions and restricted income	150	113
Debt borrowings	3,606	453
Debt payments	(3,474)	(400)
Other financing activities	(8)	1
Net cash provided by financing activities	274	167
Increase (decrease) in cash and cash equivalents	271	(508)
Cash and cash equivalents, beginning of year	729	1,237
Cash and cash equivalents, end of year	\$ 1,000	729
Supplemental disclosure of cash flow information:		
Cash paid for interest (net of amounts capitalized)	\$ 191	142

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

(1) Basis of Presentation and Significant Accounting Policies

(a) Reporting Entity

Providence Health & Services (PHS), a Washington nonprofit corporation, is a Catholic healthcare system sponsored by the public juridic person, Providence Ministries.

Effective July 1, 2016, Providence St. Joseph Health (the Health System), a Washington nonprofit corporation, became the sole corporate member of both PHS and St. Joseph Health System (SJHS). SJHS, a California nonprofit public benefit corporation, is a Catholic healthcare system sponsored by the public juridic person, St. Joseph Health Ministry. Due to the circumstances of the business combination between PHS and SJHS, through the alignment under the Health System, the transaction qualified for acquisition accounting with PHS as the acquirer of SJHS.

The Health System seeks to improve the health of the communities it serves, especially the poor and vulnerable. The Health System operations includes 50 hospitals and a comprehensive range of services provided across Alaska, California, Montana, New Mexico, Oregon, Texas, and Washington. The Health System also provides population health management through various affiliated licensed insurers and other risk-bearing entities.

The Health System has filed for an Internal Revenue Service determination letter and believes that it is exempt from federal income tax as a charitable organization under Section 501(c)(3). PHS, SJHS, and substantially all of the various corporations within the Health System have been granted exemptions from federal income tax as charitable organizations under Section 501(c)(3) of the Internal Revenue Code.

The accompanying combined balance sheets and related combined statements of operations, statements of changes in net assets, and statements of cash flows reflect the PHS financial position and results of operations as of and for the year ended December 31, 2015 and the Health System financial position and results of operations as of and for the year ended December 31, 2016. The Health System results of operations for the year ended December 31, 2016 include twelve months of results of operations for PHS and six months of results of operations for SJHS.

(b) Basis of Presentation

The accompanying combined financial statements of the Health System were prepared in accordance with U.S. generally accepted accounting principles and include the assets, liabilities, revenues, and expenses of all wholly owned affiliates, majority-owned affiliates over which the Health System exercises control, and, when applicable, entities in which the Health System has a controlling financial interest.

Intercompany balances and transactions have been eliminated in combination.

PROVIDENCE ST. JOSEPH HEALTH

Notes to Combined Financial Statements

December 31, 2016 and 2015

(In millions of dollars)

(c) Performance Indicator

The performance indicator is the excess of revenues over expenses. Changes in unrestricted net assets that are excluded from the performance indicator include net assets released from restriction for the purchase of property plant and equipment, certain changes in funded status of pension and other postretirement benefit plans, restricted contributions from affiliations, net changes in noncontrolling interests in combined joint ventures, and certain other activities.

(d) Operating and Nonoperating Activities

The Health System's primary mission is to meet the healthcare needs in its market areas through a broad range of general and specialized healthcare services, including inpatient acute care, outpatient services, physician services, long-term care, population health management, and other healthcare and health insurance services. Activities directly associated with the furtherance of this mission are considered to be operating activities. Other activities that result in gains or losses peripheral to the Health System's primary mission are considered to be nonoperating. Nonoperating activities include investment earnings, gains or losses from debt extinguishment, contributions from affiliations, and certain other activities.

(e) Use of Estimates and Assumptions

The preparation of the combined financial statements in conformity with U.S. generally accepted accounting principles requires the use of estimates and assumptions that affect the reported amounts of assets and liabilities and the reported amounts of revenues and expenses during the reporting periods. Significant estimates and assumptions are used for, but not limited to: (1) allowance for contractual revenue adjustments; (2) allowance for doubtful accounts; (3) fair value of acquired assets and assumed liabilities in business combinations; (4) useful lives of depreciable and amortizable assets; (5) fair value of investments; (6) reserves for self-insured healthcare plans; (7) reserves for professional, workers' compensation and general insurance liability risks; (8) reserves for underwritten prepaid healthcare contracts including managed care contracts and capitation agreements, and (9) contingency and litigation reserves.

The accounting estimates used in the preparation of the combined financial statements will change as new events occur, additional information is obtained or the operating environment changes. Assumptions and the related estimates are updated on an ongoing basis and external experts may be employed to assist in the evaluation, as considered necessary. Actual results could materially differ from those estimates.

(f) Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with an original or remaining maturity of three months or less when acquired.

(g) Supplies Inventory

Supplies inventory is stated at the lower of cost (first-in, first-out) or market.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

(h) Property, Plant, and Equipment

Property, plant, and equipment are stated at cost. Improvements and replacements of plant and equipment are capitalized, maintenance and repairs are expensed. The provision for depreciation is determined by the straight-line method, which allocates the cost of tangible property equally over its estimated useful life or lease term. Impairment of property, plant, and equipment is assessed when there is evidence that events or changes in circumstances have made recovery of the net carrying value of assets unlikely.

Interest capitalized on amounts expended during construction is a component of the cost of additions to be allocated to future periods through the provision for depreciation. Capitalization of interest ceases when the addition is substantially complete and ready for its intended use.

Property, plant, and equipment and the total accumulated depreciation at December 31, 2016 and 2015 are shown below:

	Approximate useful life (years)	2016	2015
Land	—	\$ 1,419	757
Buildings and improvements	5–60	8,638	5,834
Equipment:			
Fixed	5–25	1,127	1,056
Major movable and minor	3–20	5,466	4,406
Rental property	15–40	941	914
Construction in progress	—	888	275
		<u>18,479</u>	<u>13,242</u>
Less accumulated depreciation		<u>7,457</u>	<u>6,661</u>
Property, plant, and equipment, net		<u>\$ 11,022</u>	<u>6,581</u>

Construction in progress primarily represents renewal and replacement of various facilities in the Health System's operating divisions, as well as costs capitalized to software development.

(i) Other Assets

Other assets primarily consist of investments in nonconsolidated joint ventures, beneficial interest in noncontrolled foundations, notes receivable, goodwill, and other intangible assets.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

Other assets at December 31, 2016 and 2015 are as follows:

	2016	2015
Investment in nonconsolidated joint ventures	\$ 285	141
Intangible assets	253	58
Goodwill	158	112
Beneficial interest in noncontrolled foundations	146	128
Other	276	101
Total other assets	\$ 1,118	540

Goodwill is recorded as the excess of cost over fair value of the acquired net assets. Indefinite-lived intangible assets are recorded at fair value using various methods depending on the nature of the intangible asset. Both goodwill and indefinite-lived intangible assets are tested at least annually for impairment. Definite-lived intangible assets are amortized using the straight-line method over the estimated useful lives of the assets.

The Health System recorded impairment of \$36 and \$0 during the years ended December 31, 2016 and 2015, respectively. The goodwill impairment recognized during the year ended December 31, 2016 was attributable to medical foundation acquisitions made in previous years.

(j) Investments Including Assets Whose Use Is Limited

The Health System has designated all of its investments in debt and equity securities, hedge funds, and commingled funds as trading securities. These investments are reported on the combined balance sheets at fair value on a trade-date basis.

Investment sales and purchases initiated prior to and settled subsequent to the combined balance sheet date result in amounts due from and to brokers. As of December 31, 2016, the Health System recorded a receivable of \$136 for investments sold but not settled and a payable of \$375 for investments purchased but not settled in other current assets and other current liabilities, respectively, in the accompanying combined balance sheets.

Assets whose use is limited primarily include assets held by trustees under indenture agreements, self-insurance funds, funds held for the payment of health plan medical claims and other statutory reserve requirements, assets held by related foundations, and designated assets set aside by management of the Health System for future capital improvements and other purposes, over which management retains control.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

Investment income from investments including assets whose use is limited are included in net nonoperating gains (losses) and are comprised of the following for the years ended December 31, 2016 and 2015:

	2016	2015
Interest and dividend income	\$ 87	65
Net realized (losses) gains on sale of trading securities	(9)	25
Change in net unrealized gains (losses) on trading securities	325	(204)
Investment income (losses), net	\$ 403	(114)

(k) Derivative Instruments

The Health System uses derivative financial instruments (interest rate swaps) to manage its interest rate exposure and overall cost of borrowing. As of December 31, 2016, the Health System has interest rate swap contracts with a total current notional amount totaling \$480 with varying expiration dates. The Health System had no interest rate swap contracts as of December 31, 2015.

Derivative financial instruments are recorded at fair value taking into consideration the Health System's and the counterparties' nonperformance risk. As of December 31, 2016, the fair value of outstanding interest rate swaps was in a net liability position of \$104 and is included in other liabilities in the accompanying combined balance sheets. As of December 31, 2016, collateral posted in connection with the outstanding swap agreements was \$5 and is included in other assets in the accompanying combined balance sheets.

The interest rate swap agreements do not meet the criteria for hedge accounting and all changes in the valuation are recognized as a component of net nonoperating gains (losses) in the accompanying combined statements of operations. Settlements related to these agreements are recognized as a component of interest expense in the accompanying combined statements of operations. For the year ended December 31, 2016, the change in valuation was a \$52 gain and settlements recognized as a component of interest expense were \$7.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

The Health System also allows certain investment managers to use derivative financial instruments (futures and forward currency contracts) to manage interest rate risk related to the Health System's fixed-income holdings. The investment managers have executed master netting arrangements with the counterparties of the futures and forward currency purchase and sale contracts whereby the financial instruments held by the same counterparty are legally offset as the instruments are settled. The following table presents gross investment derivative assets and liabilities reported on a net basis at fair value included in assets whose use is limited in the combined balance sheets:

	2016	2015
Derivative assets:		
Futures contracts	\$ 394	405
Forward currency and other contracts	80	42
Total derivative assets	\$ 474	447
Derivative liabilities:		
Futures contracts	\$ (394)	(405)
Forward currency and other contracts	(76)	(42)
Total derivative liabilities	\$ (470)	(447)

(I) Self-Insurance Liabilities

The Health System has established self-insurance programs for professional and general liability and workers' compensation insurance coverage. These programs provide insurance coverage for healthcare institutions associated with the Health System. The Health System also operates insurance captives, Providence Assurance, Inc. and American Unity Group, Ltd., to self-insure or reinsure certain layers of professional and general liability risk.

The Health System accrues estimated self-insured professional and general liability and workers' compensation insurance claims based on management's estimate of the ultimate costs for both reported claims and actuarially determined estimates of claims incurred but not reported. Insurance coverage in excess of the per occurrence self-insured retention has been secured with insurers or reinsurers for specified amounts for professional, general, and workers' compensation liabilities. Decisions relating to the limit and scope of the self-insured layer and the amounts of excess insurance purchased are reviewed each year, subject to management's analysis of actuarial loss projections and the price and availability of acceptable commercial insurance.

At December 31, 2016 and 2015, the estimated liability for future costs of professional and general liability claims was \$302 and \$216, respectively. At December 31, 2016 and 2015, the estimated workers' compensation obligation was \$306 and \$163, respectively, both are recorded in other current liabilities and other liabilities in the accompanying combined balance sheets.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

(m) Net Assets

Unrestricted net assets are those that are not subject to donor-imposed stipulations. Amounts related to the Health System's noncontrolling interests in certain joint ventures are included in unrestricted net assets. Temporarily restricted net assets are those whose use by the Health System has been limited by donors to a specific time period and/or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Health System in perpetuity. Unless specifically stated by donors, gains and losses on permanently restricted net assets are recorded as temporarily restricted.

Temporarily restricted net assets are available for the following purposes at December 31, 2016 and 2015:

	<u>2016</u>	<u>2015</u>
Program support	\$ 570	184
Capital acquisition	144	60
Low-income housing and other	<u>102</u>	<u>81</u>
Total temporarily restricted net assets	<u>\$ 816</u>	<u>325</u>

(n) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Health System are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the promise to give is no longer conditional. The gifts are reported as either temporarily or permanently restricted contributions if they are received with donor stipulations that limit the use of the donated assets. When the terms of a donor restriction are met, temporarily restricted net assets are reclassified as unrestricted net assets and reported as other operating revenues in the combined statements of operations or as net assets released from restriction for donations of capital in the combined statements of changes in net assets.

(o) Net Patient Service Revenues

The Health System has agreements with governmental and other third-party payors that provide for payments to the Health System at amounts different from established charges. Payment arrangements for major third-party payors may be based on prospectively determined rates, reimbursed cost, discounted charges, per diem payments, or other methods.

Net patient service revenues are reported at the estimated net realizable amounts due from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with governmental payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as appropriate. Adjustments from finalization of prior years' cost reports and other third-party settlement estimates resulted in a decrease in net patient service revenues of \$1 for the year ended December 31, 2016 and an increase in net patient service revenues of \$45 for the years ended December 31, 2015, respectively.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

The composition of payors for the years ended December 31, 2016 and 2015, as a percentage of net patient service revenues, is as follows:

	2016	2015
Commercial	49%	48%
Medicare	32	32
Medicaid	16	17
Self-pay and other	3	3
	100%	100%

Various states in which the Health System operates have instituted a provider tax on certain patient service revenues at qualifying hospitals to increase funding from other sources and obtain additional Federal funds to support increased payments to providers for Medicaid services. The taxes are included in purchased services, professional fees, and other expenses in the accompanying combined statements of operations and were \$495 and \$528 for the years ended December 31, 2016 and 2015, respectively. These programs resulted in enhanced payments from these states in the way of lump-sum payments and per claim increases. These enhanced payments are included in net patient service revenues in the accompanying combined statements of operations and were \$616 and \$612 for the years ended December 31, 2016 and 2015, respectively.

(p) Allowance for Bad Debts

The Health System provides for an allowance against patient accounts receivable for amounts that could become uncollectible. The Health System estimates this allowance based on the aging of accounts receivable, historical collection experience by payor, and other relevant factors. There are various factors that can impact the collection trends, such as changes in the economy, which in turn have an impact on unemployment rates and the number of uninsured and underinsured patients, the increased burden of copayments to be made by patients with insurance coverage and business practices related to collection efforts. These factors continuously change and can have an impact on collection trends and the estimation process used by the Health System. The Health System records a provision for bad debts in the period of services on the basis of past experience, which has historically indicated that many patients are unresponsive or are otherwise unwilling to pay the portion of their bill for which they are financially responsible.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

The estimates made and changes affecting those estimates for the years ended December 31, 2016 and 2015 are summarized below:

	<u>2016</u>	<u>2015</u>
Changes in allowance for bad debts:		
Allowance for doubtful accounts at beginning of year	\$ 344	290
Write-off of uncollectible accounts, net of recoveries	(276)	(132)
Provision for bad debts	203	186
Allowance for bad debts at end of year	<u>\$ 271</u>	<u>344</u>

(q) Charity Care and Community Benefit

The Health System provides community benefit activities that address significant health priorities within its geographic service areas. These activities include Medicaid and Medicare shortfalls, community health services, education and research, and free and low-cost care (charity care).

Charity care is reported at cost and is determined by multiplying the charges incurred at established rates for services rendered by the Health System's cost-to-charge ratio. The cost of charity care provided by the Health System for the years ended December 31, 2016 and 2015 was \$174 and \$180, respectively.

(r) Premium and Capitation Revenues

Premium and capitation revenues are received on a prepaid basis and are recognized as revenue during the month for which the enrolled member is entitled to healthcare services. Premium and capitation revenues received for future months are recorded as unearned premiums.

(s) Functional Expenses

The Health System provides healthcare services to residents within its geographic service areas. Expenses related to providing these services for the years ended December 31, 2016 and 2015 are as follows:

	<u>2016</u>	<u>2015</u>
Healthcare expenses	\$ 13,567	10,700
Purchased healthcare expenses	1,917	1,045
General and administrative expenses	3,644	2,427
Total operating expenses	<u>\$ 19,128</u>	<u>14,172</u>

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

(t) Subsequent Events

Effective February 23, 2017 the Health System and Catholic Health Initiatives entered into an agreement with Laboratory Corporation of America to sell all of its ownership interest in Pathology Associates Medical Laboratories and its affiliated joint ventures.

The Health System has performed an evaluation of subsequent events through, March 22, 2017, the date the accompanying combined financial statements were issued.

(u) New Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update No. (ASU) 2014-09, *Revenue from Contracts with Customers*, to clarify the principles for recognizing revenue and to improve financial reporting by creating common revenue recognition guidance for U.S. generally accepted accounting principles and International Financial Reporting Standards. The amendments in the ASU can be applied either retrospectively to each prior reporting period presented or retrospectively with the cumulative effect of initially applying the update recognized at the date of the initial application along with additional disclosures. The Health System is currently evaluating the impact of ASU 2014-09, including the methods of implementation, which is effective for the fiscal year beginning on January 1, 2018.

In March 2015, the FASB issued ASU 2015-03, *Simplifying the Presentation of Debt Issuance Costs*. This update changes the presentation of debt issuance costs in the financial statements to present such costs in the balance sheet as a direct deduction from the recognized liability rather than as an asset. Amortization of the costs is reported as interest expense. The Health System adopted the standard effective January 1, 2016 and the prior year amount of \$35 has been reclassified in accordance with ASU 2015-03.

In May 2015, the FASB issued ASU 2015-07, *Fair Value Measurement (Topic 820): Disclosures for Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*, which eliminates the requirement to categorize investments in the fair value hierarchy if their fair value is measured at net asset value per share, or its equivalent (NAV), using the practical expedient in the FASB's fair value measurement guidance. The Health System elected to early adopt this standard effective December 31, 2015. As a result of the adoption of the standard, the Health System modified its fair value hierarchy disclosures.

In February 2016, the FASB issued ASU 2016-02, *Leases*, which requires lessees to recognize a lease liability and a right of use asset for all lease obligations with exception to short-term leases. The lease liability will represent the lessee's obligation to make lease payments arising from the lease measured on a discounted basis and the right of use asset will represent the lessee's right to use or control the use of a specified asset for a lease term. The lease guidance also simplifies accounting for sale-leaseback transactions. Because of the number of leases the Health System utilizes to support its operations, the adoption of ASU 2016-02 is expected to have a significant impact on the Health System's combined financial position and results of operations. The Health System is currently evaluating the extent of the anticipated impact of the adoption of ASU 2016-02, which is effective for the fiscal year beginning on January 1, 2019 with retrospective application to the earliest presented period.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

In August 2016, the FASB issued ASU 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities*, with the intent of reducing diversity in reporting practice, reduce complexity, and enhance understandability of not-for-profit (NFP) financial statements. This ASU contains the following key aspects; (A) Reduces the number of net asset classes presented from three to two: *with donor restrictions* and *without donor restrictions*; (B) Requires all NFPs to present expenses by their functional and their natural classifications in one location in the financial statements; (C) Requires NFPs to provide quantitative and qualitative information about management of liquid resources and availability of financial assets to meet cash needs within one year of the balance sheet date; and (D) Retains the options to present operating cash flows in the statement of cash flows using either the direct or indirect method. The Health System is currently evaluating the impact of ASU 2016-14, including the methods of implementation, which is effective for the fiscal year beginning January 1, 2018.

(v) Reclassifications

Certain reclassifications have been made to prior year amounts to conform to the current year presentation.

(2) Affiliations

On July 1, 2016, PHS and SJHS entered into a business combination agreement, the purpose of which was to better serve both organizations' communities, maintain strong traditions of Catholic healthcare, and provide greater affordability and access to healthcare services. As part of the business combination, PHS and SJHS aligned under a single parent corporation, Providence St. Joseph Health, with a consolidated board of directors and cosponsorship from the public juridic persons Providence Ministries and St. Joseph Health Ministry.

SJHS provides a full range of care facilities including 16 acute care hospitals, home health agencies, hospice care, outpatient services, skilled nursing facilities, community clinics, and physician groups spanning California, west Texas, and eastern New Mexico. The results of operations of these entities have been included in the combined statements of operations of the Health System since July 1, 2016, the effective date of the business combination.

The transition was accounted for as an acquisition under Accounting Standards Codification (ASC) 958-805, *Not-for-Profit Entities – Business Combinations*. The affiliation did not involve consideration and resulted in an excess of assets acquired over liabilities assumed, reported as a contribution of net assets from SJHS to the Health System of approximately \$5,644. The unrestricted portion of the contribution of \$5,163 is included in net nonoperating gains in the accompanying combined statement of operations for the year ended December 31, 2016. The remaining \$481 of the contribution was restricted and is recorded in restricted net assets in the combined statement of changes in net assets for the year ended December 31, 2016.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

The following table summarizes the fair value estimate of the SJHS assets acquired and liabilities assumed as of July 1, 2016:

Cash and cash equivalents	\$	359
Accounts receivable, net		607
Supplies inventory		66
Other current assets		290
Assets whose use is limited		3,372
Property, plant, and equipment, net		4,388
Other assets		555
Accounts payable		(146)
Accrued compensation		(344)
Other current liabilities		(569)
Long-term debt		(2,486)
Other liabilities		(448)
Total contribution of net assets	\$	<u>5,644</u>

The following are the financial results of SJHS included in the Health System's 2016 combined statement of operations during the six-month period from the date of the affiliation through December 31, 2016:

Total operating revenues	\$	3,520
Excess of revenue over expenses from operations		46
Excess of revenues over expenses		130

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

The following unaudited pro forma combined financial information presents the Health System's results as if the affiliation had been reported as of the beginning of the Health System's fiscal year of January 1, 2015:

	2016		2015	
	Actual	Pro forma (unaudited)	Actual	Pro forma (unaudited)
Total operating revenues	\$ 18,879	22,157	14,434	20,741
(Deficit) excess of revenues over expenses from operations	(249)	(265) (1)(2)	262	260 (2)
Excess of revenues over expenses	5,231	57 (1)	77	5,175 (3)

- (1) Includes the historical results of SJHS for the six-month period ended June 30, 2016 prior to the affiliation, including the impact of purchase accounting adjustments.
- (2) Includes additional depreciation related to the fair value adjustments and useful life adjustments recorded related to the affiliation.
- (3) Includes the net contribution from the affiliation, in accordance with applicable accounting guidance.

Effective April 1, 2016, the Health System entered into a business combination agreement with the Institute for Systems Biology (ISB). The transaction was accounted for as an acquisition under ASC 958-805. The affiliation resulted in an excess of assets acquired over liabilities assumed, reported as a contribution from ISB to the Health System of approximately \$19. The unrestricted portion of the contribution of \$4 is included in net nonoperating gains in the accompanying combined statement of operations for the year ended December 31, 2016. The remaining \$15 of the contribution was restricted and is recorded in restricted net assets in the combined statement of changes in net assets for year ended December 31, 2016.

(3) Fair Value Measurements

ASC Topic 820 (Topic 820), *Fair Value Measurements*, requires a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs include quoted prices (unadjusted) in active markets for identical assets or liabilities that the Health System has the ability to access at the measurement date.
- Level 2 inputs include inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly.
- Level 3 inputs are unobservable inputs for the asset or liability.

The level in the fair value hierarchy within which a fair value measurement in its entirety falls is based on the lowest-level input that is significant to the fair value measurement in its entirety.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

(a) Assets Whose Use Is Limited

The fair value of assets whose use is limited, other than those investments measured using NAV as a practical expedient for fair value, is estimated using quoted market prices or other observable inputs when quoted market prices are unavailable.

The composition of assets whose use is limited at December 31, 2016 is set forth in the following table:

	December 31, 2016	<u>Fair value measurements at reporting date using</u>		
		<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>
Management-designated cash and investments:				
Cash and cash equivalents	\$ 572	572	—	—
Equity securities:				
Domestic	1,000	1,000	—	—
Foreign	280	280	—	—
Mutual funds	828	828	—	—
Domestic debt securities:				
State and federal government	1,518	1,011	507	—
Corporate	766	—	766	—
Other	503	—	503	—
Foreign debt securities	172	—	172	—
Commingled funds	575	575	—	—
Other	32	20	12	—
Investments measured using NAV	<u>2,752</u>			
Total management-designated cash and investments	<u>8,998</u>			
Gift annuities, trusts, and other	131	32	11	88
Funds held by trustee:				
Cash and cash equivalents	147	147	—	—
Domestic debt securities	198	68	130	—
Foreign debt securities	<u>23</u>	—	23	—
Total funds held by trustee	<u>368</u>			
Total assets whose use is limited	<u>\$ 9,497</u>			

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

The composition of assets whose use is limited at December 31, 2015 is set forth in the following table:

	<u>December 31,</u> <u>2015</u>	<u>Fair value measurements at reporting date using</u>		
		<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>
Management-designated cash and investments:				
Cash and cash equivalents	\$ 615	615	—	—
Equity securities:				
Domestic	526	526	—	—
Foreign	68	68	—	—
Mutual funds	488	488	—	—
Domestic debt securities:				
State and federal government	1,029	717	312	—
Corporate	644	—	644	—
Other	255	—	255	—
Foreign debt securities	105	—	105	—
Commingled funds	216	216	—	—
Other	1	1	—	—
Investments measured using NAV	<u>1,186</u>			
Total management-designated cash and investments	<u>5,133</u>			
Gift annuities, trusts, and other	94	24	8	62
Funds held by trustee:				
Cash and cash equivalents	177	177	—	—
Domestic debt securities	134	64	70	—
Foreign debt securities	<u>16</u>	<u>—</u>	<u>16</u>	<u>—</u>
Total funds held by trustee	<u>327</u>			
Total assets whose use is limited	<u>\$ 5,554</u>			

The Health System participates in various funds that are not actively marketed on an open exchange. These investments consist of shares or units in investment funds as opposed to direct interests in the funds' underlying holdings, which may be marketable. Due to the nature of these funds the NAV per share, or its equivalent, reported by each fund manager is used as a practical expedient to estimate the fair value of the Health System's interest therein. Management believes that the carrying amounts of these financial instruments, provided by the fund managers, are reasonable estimates of fair value.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

The following table presents information, including unfunded commitments as of December 31, 2016, for investments where the NAV was used to estimate the value of the investments as of December 31:

	Fair value		Unfunded commitments	Redemption frequency	Redemption notice period
	2016	2015			
Hedge funds:					
Equity hedge	\$ 537	175	—	Monthly, quarterly, or annually	30–120 days
Multistrategy	364	331	—	Monthly or quarterly	5–90 days
Market dependent	184	99	—	Monthly or quarterly	2–60 days
Fund of funds	141	—	—	Quarterly or annually	90 days
Event driven	114	—	—	Monthly, quarterly, or annually	45–150 days
Commingled funds	1,022	572	—	Monthly, quarterly, or annually	6–90 days
Private equity	210	9	135	Not applicable	Not applicable
Private real estate and real assets	180	—	54	Not applicable	Not applicable
Total	\$ 2,752	1,186	189		

The following is a summary of the nature of these investments and their associated risks:

Hedge funds are portfolios of investments that use advanced investment strategies such as leveraged, long, short, and derivative positions in both domestic and international markets with the goal of diversifying portfolio risk and generating return. The Health System's investments in hedge funds include certain funds with provisions that limit the Health System's ability to access assets invested. These provisions include lockup terms that range up to three years from the subscription date or are continuous and determined as a percent of total assets invested. The Health System is in various stages of the lockup periods dependent on hedge fund and period of initial investments.

Commingled funds are funds that pursue diversification of domestic and foreign equity and fixed-income securities. The Health System's investments in commingled funds have no lockup provisions or other restrictions, other than those outlined in the table above, that limit its ability to access cash.

Private equity, private real estate, and real asset funds are funds that make opportunistic investments that are primarily private in nature. These investments cannot be redeemed by the Health System; rather the Health System has committed an amount to invest in the private funds over the respective commitment periods. After the commitment period has ended, the nature of the investments in this category is that the distributions are received through the liquidation of the underlying assets.

(b) Derivative Instruments

The fair value of the interest rate swaps is based on independent valuations obtained and are determined by calculating the value of the discounted cash flows of the differences between the fixed interest rate of the interest rate swaps and the counterparty's forward London Interbank Offered Rate curve, which is the input used in the valuation, taking also into account any nonperformance risk. Collateral posted for the interest rate swaps consist of cash and U.S. government securities, which are both categorized as Level 1 financial instruments.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

The following table presents the fair value of swaps and related collateral as of December 31, 2016:

	<u>December 31, 2016</u>	<u>Fair value measurements at reporting date using</u>		
		<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>
Cash collateral held by swap counterparty	\$ 5	5	—	—
Liabilities under interest rate swaps	104	—	104	—

(c) Debt

The fair value of long-term debt is based on Level 2 inputs, such as the discounted value of the future cash flows using current rates for debt with the same remaining maturities, considering the existing call premium and protection. The carrying value and fair value of long-term debt was \$6,749 and \$6,980, respectively, as of December 31, 2016, and \$4,079 and \$4,368, respectively, as of December 31, 2015.

(d) Assets Measured Using Significant Unobservable Inputs

The following table presents the Health System's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in Topic 820 for the years ended December 31, 2016 and 2015:

Balance at December 31, 2014	\$ 27
Total realized and unrealized gains (losses), net	—
Total purchases	30
Total sales	(2)
Transfers into Level 3	11
Transfers out of Level 3	(4)
Balance at December 31, 2015	62
Level 3 assets acquired through affiliation	8
Total realized and unrealized gains (losses), net	1
Total purchases	16
Total sales	(3)
Transfers into Level 3	4
Transfers out of Level 3	—
Balance at December 31, 2016	<u>\$ 88</u>

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

There were no significant transfers between assets classified as Level 1 and Level 2 during the years ended December 31, 2016 and 2015.

Level 3 assets include charitable remainder trusts, real property, and equity investments in healthcare technology start-ups through the Health System's innovation venture capital fund. Fair values of real property were estimated using a market approach. Fair values of charitable remainder trusts were estimated using an income approach. Fair value of equity investments in healthcare technology start-ups were estimated using a combination of income and market approach.

(4) Debt

(a) Short-Term and Long-Term Debt

The Health System has borrowed master trust debt issued through the following:

- California Health Facilities Financing Authority (CHFFA)
- Alaska Industrial Development and Export Authority (AIDEA)
- Washington Health Care Facilities Authority (WHCFA)
- Montana Facility Finance Authority (MFFA)
- Lubbock Health Facilities Development Corp (LHFDC)
- Oregon Facilities Authority (OFA)

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

Short-term and long-term unpaid principal at December 31, 2016 and 2015 consists of the following:

	Maturing through	Coupon rates	Unpaid principal	
			2016	2015
Master trust debt:				
Fixed rate:				
Series 1997, Direct Obligation Notes	2017	7.70%	\$ 1	2
Series 2005, Direct Obligation Notes	2030	4.31 – 5.39%	42	45
Series 2006A, WHCFA Revenue Bonds	2036	4.50 – 5.00%	—	211
Series 2006B, MFFA Revenue Bonds	2026	4.00 – 5.00%	—	54
Series 2006C, WHCFA Revenue Bonds	2033	5.25%	69	69
Series 2006D, WHCFA Revenue Bonds	2033	5.25%	69	69
Series 2006E, WHCFA Revenue Bonds	2033	5.25%	26	26
Series 2006H, AIDEA Revenue Bonds	2036	5.00%	—	52
Series 2008B, LHFDC Revenue Bonds	2023	4.00 – 5.00%	46	—
Series 2008C, CHFFA Revenue Bonds	2038	3.00 – 6.50%	12	16
Series 2009A, Direct Obligation Notes	2019	5.05 – 6.25%	100	165
Series 2009A, CHFFA Revenue Bonds	2039	5.50 – 5.75%	185	—
Series 2009B, CHFFA Revenue Bonds	2039	5.50%	150	150
Series 2009B, CHFFA Revenue Bonds	2021	3.00 – 5.25%	42	—
Series 2009C, CHFFA Revenue Bonds	2034	5.00%	91	—
Series 2009D, CHFFA Revenue Bonds	2034	1.70%	40	—
Series 2010A, WHCFA Revenue Bonds	2039	4.88 – 5.25%	174	174
Series 2011A, AIDEA Revenue Bonds	2041	5.00 – 5.50%	123	123
Series 2011B, WHCFA Revenue Bonds	2021	2.00 – 5.00%	51	59
Series 2011C, OFA Revenue Bonds	2026	3.50 – 5.00%	17	18
Series 2012A, WHCFA Revenue Bonds	2042	2.00 – 5.00%	489	498
Series 2012B, WHCFA Revenue Bonds	2042	4.00 – 5.00%	100	100
Series 2013A, OFA Revenue Bonds	2024	2.00 – 5.00%	61	67
Series 2013A, CFHHA Revenue Bonds	2037	4.00 – 5.00%	325	—
Series 2013B, CFHHA Revenue Bonds	2043	4.15 – 4.26%	110	—
Series 2013C, CFHHA Revenue Bonds	2043	4.15 – 4.26%	110	—
Series 2013D, Direct Obligation Notes	2023	4.38%	252	252
Series 2013D, CFHHA Revenue Bonds	2043	4.15 – 4.26%	110	—
Series 2014A, CHFFA Revenue Bonds	2038	2.00 – 5.00%	273	274
Series 2014B, CHFFA Revenue Bonds	2044	4.25 – 5.00%	119	119
Series 2014C, WHCFA Revenue Bonds	2044	4.00 – 5.00%	92	92
Series 2014D, WHCFA Revenue Bonds	2041	5.00%	179	179
Series 2015A, WHCFA Revenue Bonds	2045	4.00%	78	78
Series 2015C, OFA Revenue Bonds	2045	4.00 – 5.00%	71	71
Series 2016A, CHFFA Revenue Bonds	2047	2.50 – 5.00%	448	—
Series 2016B, CHFFA Revenue Bonds	2036	1.25 – 4.00%	286	—
Series 2016H, Direct Obligation Bonds	2036	2.75%	300	—
Series 2016I, Direct Obligation Bonds	2047	3.74%	400	—
			5,041	2,963
Total fixed rate				

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

	Maturing through	Effective interest rate (1)		Unpaid principal	
		2016	2015	2016	2015
Variable rate:					
Series 2012C, WHCFA Revenue Bonds	2042	0.43%	0.05%	\$ 80	80
Series 2012D, WHCFA Revenue Bonds	2042	0.43	0.05	80	80
Series 2012E, Direct Obligation Notes	2042	0.57	0.17	231	234
Series 2013C, OFA Revenue Bonds	2022	1.41	1.08	117	135
Series 2013E, Direct Obligation Notes	2017	4.79	3.00	100	200
Series 2016C, LHFDC Revenue Bonds	2030	0.24	—	39	—
Series 2016D, WHCFA Revenue Bonds	2036	1.04	—	106	—
Series 2016E, WHCFA Revenue Bonds	2036	0.96	—	106	—
Series 2016F, MFFA Revenue Bonds	2026	0.93	—	50	—
Series 2016G, Direct Obligation Notes	2047	0.76	—	100	—
Total variable rate				1,009	729
Commercial Paper, Series 2015B	2016	0.42	0.21	—	125
U.S. Bank Credit Facility	2016	0.92	0.56	—	13
Wells Fargo Credit Facility	2021	1.22	—	252	—
Unpaid principal, master trust debt				6,302	3,830
Premiums, discounts, and unamortized financing costs, net				167	83
Master trust debt, including premiums and discounts, net				6,469	3,913
Other long-term debt				280	166
Total debt				\$ 6,749	4,079

(1) Variable rate debt, commercial paper, and credit facilities carry floating interest rates attached to indexes, which are subject to change based on market conditions.

In September and November 2016, the Health System issued \$1,835 Series 2016A through 2016I revenue bonds and direct obligation notes. The intended uses of funds included refinancing legacy SJHS and PHS master trust debt and repayment of outstanding lines of credit and commercial paper. Certain issues within the 2016 series debt included remarketing provisions for which the Health System purchased supporting credit facilities that allow the Health System to treat the obligations as noncurrent though remarketing may occur within less than one year.

In August and September 2015, the Health System issued \$149 of Series 2015A and 2015C fixed rate revenue bonds. The intended use of funds was to cover certain capital investment.

In connection with the Series 2016A-I issuances and the Series 2015A-C issuances, the Health System recorded losses due to extinguishment of debt of \$60 and \$0 in the year ended December 31, 2016 and 2015, respectively, which were recorded in net nonoperating gains (losses) in the accompanying combined statements of operations.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

The following table reflects classification of long-term debt obligations in the accompanying combined balance sheets as of December 31:

	<u>2016</u>	<u>2015</u>
Current portion of long-term debt	\$ 200	245
Short-term master trust debt	153	138
Long-term debt, classified as a long-term liability	<u>6,396</u>	<u>3,696</u>
Total debt	<u>\$ 6,749</u>	<u>4,079</u>

Short-term master trust debt represents debt issues with remarketing provisions unsupported by credit facilities with mandatory redemption within one year of the December 31, 2016 and 2015.

(b) Other Long-Term Debt

Other long-term debt primarily includes capital leases, notes payable, and bonds that are not under the master trust indenture. Other long-term debt at December 31, 2016 and 2015 consists of the following:

	<u>2016</u>	<u>2015</u>
Capital leases	\$ 107	104
Notes payable	154	47
Bonds not under master trust indenture and other	<u>19</u>	<u>15</u>
Total other long-term debt	<u>\$ 280</u>	<u>166</u>

(c) Debt Service

Scheduled principal payments of long-term debt, considering all obligations under the master trust indenture as due according to their long-term amortization schedule, for the next five years and thereafter are as follows:

	<u>Master trust</u>	<u>Other</u>	<u>Total</u>
2017	\$ 182	18	200
2018	88	11	99
2019	192	8	200
2020	98	8	106
2021	355	9	364
Thereafter	<u>5,387</u>	<u>226</u>	<u>5,613</u>
Scheduled principal payments of long-term debt	<u>\$ 6,302</u>	<u>280</u>	<u>6,582</u>

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

(5) Retirement Plans

(a) Defined Benefit Plans

The Health System sponsors various frozen defined benefit retirement plans. The measurement dates for the defined benefit plans are December 31, 2016 and 2015. A rollforward of the change in projected benefit obligation and change in the fair value of plan assets for the defined benefit plans is as follows:

	2016	2015
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	\$ 2,600	2,827
Service cost	22	25
Interest cost	94	114
Actuarial loss (gain)	140	(135)
Benefits paid and other	(176)	(231)
Projected benefit obligation at end of year	2,680	2,600
Change in fair value of plan assets:		
Fair value of plan assets at beginning of year	1,535	1,782
Actual return on plan assets	119	(106)
Employer contributions	81	90
Benefits paid and other	(176)	(231)
Fair value of plan assets at end of year	1,559	1,535
Funded status	(1,121)	(1,065)
Unrecognized net actuarial loss	552	470
Unrecognized prior service cost	4	5
Net amount recognized	\$ (565)	(590)
Amounts recognized in the combined balance sheets consist of:		
Current liabilities	\$ (1)	(1)
Noncurrent liabilities	(1,120)	(1,064)
Unrestricted net assets	556	475
Net amount recognized	\$ (565)	(590)
Weighted average assumptions:		
Discount rate	4.40%	4.58%
Rate of increase in compensation levels	3.50	3.50
Long-term rate of return on assets	6.90	6.80

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

Net periodic pension cost for the defined benefit plans for 2016 and 2015 includes the following components:

	<u>2016</u>	<u>2015</u>
Components of net periodic pension cost:		
Service cost	\$ 22	25
Interest cost	94	114
Expected return on plan assets	(107)	(116)
Amortization of prior service cost	1	1
Recognized net actuarial loss	<u>19</u>	<u>26</u>
Net periodic pension cost	<u>\$ 29</u>	<u>50</u>
Special recognition – settlement expense	\$ 28	33

Certain plans sponsored by the Health System allow participants to receive their benefit through a lump-sum distribution upon election. When lump-sum distributions exceed the combined total of service cost and interest cost during a reporting period settlement expense is recognized. Settlement expense represents the proportional recognition of unrecognized actuarial loss and prior service cost. Settlement expense for the years ended December 31, 2016 and 2015 is included in net nonoperating gains (losses) in the accompanying combined statements of operations.

The accumulated benefit obligation was \$2,628 and \$2,556 at December 31, 2016 and 2015, respectively.

The following pension benefit payments reflect expected future service. Payments expected to be paid over the next 10 years are as follows:

2017	\$ 183
2018	191
2019	195
2020	199
2021–2026	<u>1,106</u>
	<u>\$ 1,874</u>

The Health System expects to contribute approximately \$96 to the defined benefit plans in 2017.

The expected long-term rate of return on plan assets is the expected average rate of return on the funds invested currently and on funds to be invested in the future in order to provide for the benefits included in the projected benefit obligation. The Health System used 6.9% and 6.8% in calculating the 2016 and 2015 expense amounts, respectively. This assumption is based on capital market assumptions and the plan's target asset allocation.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

The Health System continues to monitor the expected long-term rate of return. If changes in those parameters cause 6.9% to be outside of a reasonable range of expected returns, or if actual plan returns over an extended period of time, suggest that general market assumptions are not representative of expected plan results, the Health System may revise this estimate prospectively.

The target asset allocation and expected long-term rate of return on assets (ELTRA) for the years ended December 31, 2016 and 2015, respectively, were as follows:

	<u>2016 Target</u>	<u>2016 ELTRA</u>	<u>2015 Target</u>	<u>2015 ELTRA</u>
Cash and cash equivalents	1%	1%–3%	2%	1%–3%
Equity securities	42	5%–9%	47	5%–8%
Debt securities	35	2%–5%	35	2%–6%
Other securities	22	5%–9%	16	5%–8%
Total	<u>100%</u>	<u>6.90%</u>	<u>100%</u>	<u>6.80%</u>

The following table presents the Health System's defined benefit plan assets measured at fair value at December 31, 2016:

	<u>December 31 2016</u>	<u>Fair value measurements at reporting date using</u>		
		<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>
Assets:				
Cash and cash equivalents	\$ 58	58	—	—
Equity securities:				
Domestic	192	192	—	—
Foreign	37	37	—	—
Mutual funds	104	104	—	—
Domestic debt securities:				
State and government	251	173	78	—
Corporate	115	—	115	—
Other	15	—	15	—
Foreign debt securities	30	—	30	—
Commingled funds	157	157	—	—
Investments measured using NAV	663			
Transactions pending settlement, net	<u>(63)</u>			
Total	<u>\$ 1,559</u>			

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

The following table presents the Health System's defined benefit plan assets measured at fair value at December 31, 2015:

	December 31, 2015	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
Assets:				
Cash and cash equivalents	\$ 64	64	—	—
Equity securities:				
Domestic	262	262	—	—
Foreign	37	37	—	—
Mutual funds	31	31	—	—
Domestic debt securities:				
State and government	242	169	73	—
Corporate	116	—	116	—
Other	8	—	8	—
Foreign debt securities	15	—	15	—
Commingled funds	154	—	154	—
Other	8	—	8	—
Investments measured using NAV	623			
Transactions pending settlement, net	(25)			
Total	\$ 1,535			

The Health System's defined benefit plans participate in various funds that are not actively marketed on an open exchange. These investments consist of shares or units in investment funds as opposed to direct interests in the funds' underlying holdings, which may be marketable. Due to the nature of these funds the NAV per share, or its equivalent, reported by each fund manager is used as a practical expedient to estimate the fair value of the Health System's interest therein. Management believes that the carrying amounts of these financial instruments provided by the fund managers are reasonable estimates of fair value.

The following table presents information for investments where either the NAV per share or its equivalent was used to value the investments as of December 31:

	Fair value		Redemption frequency	Redemption notice period
	2016	2015		
Hedge funds:				
Multistrategy	\$ 162	173	Monthly or quarterly	5 – 90 days
Equity hedge	74	93	Monthly or quarterly	30 – 65 days
Fund of funds	1	4	Monthly	30 days
Commingled funds	426	353	Monthly	6 – 30 days
Total	\$ 663	623		

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2016 and 2015
(In millions of dollars)

(b) Defined Contribution Plans

The Health System sponsors various defined contribution retirement plans that cover substantially all employees. The plans provide for employer matching contributions in an amount equal to a percentage of employee pretax contributions, up to a maximum amount. In addition, the Health System makes contributions to eligible employees based on years of service. Retirement expense related to these plans was \$440 and \$323 in 2016 and 2015, respectively, and is reflected in salaries and benefit expense in the accompanying combined statements of operations.

(6) Commitments and Contingencies

(a) Commitments

Firm purchase commitments, primarily related to construction and equipment and software acquisition, at December 31, 2016 are approximately \$249.

(b) Operating Leases

Leases

The Health System leases various medical and office equipment and buildings under operating leases. Future minimum lease commitments under noncancelable operating leases for the next five years and thereafter are as follows:

2017	\$	216
2018		205
2019		187
2020		168
2021		148
Thereafter		896
	\$	1,820

Rental expense, including month-to-month leases and contingent rents, was \$302 and \$217 for the years ended December 31, 2016 and 2015, respectively, and is included in other expenses in the accompanying combined statements of operations.

(c) Litigation

The healthcare industry is subject to numerous laws and regulations from federal, state, and local governments. Compliance with these laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time. Government monitoring and enforcement activity continues with respect to investigations and allegations concerning possible violations by healthcare providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of patient services previously billed. Institutions within the Health System are subject to similar regulatory reviews.

Management is aware of certain asserted and unasserted legal claims and regulatory matters arising in the course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Health System's combined financial statements.

Management's Discussion and Analysis of Financial Condition and Results of Operations

Year ended December 31, 2017

About Providence St. Joseph Health

Our Organization

Providence St. Joseph Health (the System) has been a strong and stable force in health care for more than 160 years. In 2016, Providence Health & Services and St. Joseph Health came together as one national health system with the goal of improving the health of the communities we serve, especially the poor and vulnerable. During 2017, the System generated revenues of \$23 billion, an increase of 5 percent over the prior year. In addition, we have invested \$1.6 billion in community benefit in support of our Mission.

“Together, we can invest more in the needs of everyone we serve, especially the most vulnerable.”
**-Rod Hochman, M.D.,
 President and CEO**

While we have sustained our performance, we strive to increase access to health care and bring quality, compassionate care to those we serve, regardless of coverage or ability to pay. We are privileged to serve in fast growing markets in the western United States with growing populations, which has led to consistent increases in our services in these markets. We believe that health care is a basic human right and experience has shown us that when individuals and families have access to care, quality of life improves. We offer a comprehensive range of industry-leading services, including an integrated care delivery system for inpatient and outpatient services, directly employed and affiliated physicians, health plans, senior care and housing programs, financial assistance programs for those unable to pay their medical bills and educational ministries. With a shared commitment to transform health care, we are pioneering new care settings, population health, and solutions in clinical research and investing in digital technologies. Together, we are bringing quality care to all, with a focus on those most in need, and we are consistent advocates on behalf of the vulnerable and marginalized.

We employ more than 114,000 caregivers (employees) who serve in 50 hospitals, over 800 clinics and hundreds of programs and services across seven states.



Industry Trends

Providers are adapting to a rapidly changing industry and finding innovative ways to provide better, more affordable care and consumer-centric services. More hospitals and health systems are making innovative digital offerings that better engage customers, improve continuum of care and reduce clinical and operational variations and costs. With the advent of cloud computing and regulatory changes improving access for patients and sharing medical information, there will be more demand for applications that reduce friction in the system. These advancements will also improve collaboration between caregivers and patients using real-time data that improves managed and preventive care and enables more effective, customized health regimens. Advances in technology are improving the quality of care, such as direct-to-consumer tests, integrating genomic data and other personal health information with clinical labs. We anticipate the following developments ahead:

- **Technology** - Digital transformation will be increasingly important to empower patients to become more involved in their care as providers leverage cloud computing, artificial intelligence and machine learning, and consumer engagement platforms in health care
- **Personalized Medicine** - Using medicine, big data/analytics, and social networks
- **Population Health** - A stronger focus on the social determinants of health is ahead through ongoing improvements in analytics and care management to help prevent illness and care for those with chronic conditions
- **Workforce** - Sourcing a wide base of healthcare talent to meet the challenges of providing cost-effective, high-quality care will demand new and inventive workforce strategies
- **Ambulatory and Home Health** - Providers will offer convenient at-home services that utilize video, email, online chat or text to provide patients with more opportunities to manage their health and wellness
- **Partnerships** - Successful traditional and non-traditional partnerships will expand access, improve efficiencies, and help reduce or stabilize costs for medical supplies and pharmaceuticals

Policy and Advocacy

Our advocacy agenda for 2018 maintains a vigorous focus on protecting and advancing gains in health insurance coverage with a special emphasis on Medicaid and Medicare. Responding to the needs of our communities, advocacy will endorse initiatives to help pioneer new paths in health care, advance population health strategies and respond to provider shortages. The System will continue to be a voice for the vulnerable in our communities and nation promoting legislative solutions that improve quality and access to care.

Throughout 2017, our family of organizations served as strong advocates in Congress and state legislatures for the preservation of coverage gains and access to care, and the stability of health insurance markets. As a mission-driven health system, we maintain a special focus on serving those who are poor and vulnerable and advocating for safety net programs that they depend on, particularly Medicaid. Uncertainty about the scope of government-sponsored insurance and levels of reimbursement was significant in 2017, and we expect these trends to continue into 2019, as governments face budgetary restraints. At least two of the states we serve are now reducing Medicaid payments or taxing providers and insurers for budget relief. Even with passage of a bill to fund the federal Children's Health Insurance Program for 10 years, we do not expect government reimbursement to keep up with industry costs and have developed operational and financial management strategies to respond accordingly.

The tax overhaul passed in late 2017 maintains not-for-profit hospital access to tax-exempt debt, which is an important tool in helping us to manage our infrastructure costs and allowing for continued investments in

Together, we answer the call of every person we serve: Know me, care for me, ease my way.

our communities. Another provision repeals the Affordable Care Act's individual mandate in 2019 that requires most Americans to have a minimum level of health insurance. As a result, the uninsured rate is expected to rise by several million, leading to poorer health and more need for free or subsidized care.

Strategy

As health care evolves, we are responding with a vision and core strategy to transform and innovate at scale. Across the western United States, we share one strategic plan designed to improve the health of entire populations by supporting the well-being of each person served. That integrated strategic and financial plan is supported by three key principles:

Strengthen the Core. We will deliver outstanding, affordable health care, housing, education and other essential services to our patients and communities by:

- Delivering safe, compassionate, high-value health care
- Stewarding our resources with a rigor and discipline that enables improved operational earnings into the future
- Fostering community commitment to our Mission via philanthropy
- Creating a work experience where caregivers are developed, fulfilled and inspired to carry on the Mission

Be Our Communities' Health Partner. We will be our communities' health partner, aiming for physical, spiritual and emotional well-being. We seek to ease the way of our neighbors by:

- Transforming care and improving population health outcomes, especially for the poor and vulnerable
- Leading the way in improving our nation's mental and emotional well-being
- Extending our commitment to whole person care for people at every age and stage of life
- Engaging with partners in addressing the social determinants of health, with a focus on education, housing and the environment
- Being the preferred health partner for those we serve

Transform Our Future. We will respond to the evolving health care landscape, pursuing new opportunities that transform our services, in a strategic and effective manner. We seek to expand our share of lives and health spend and further sustain our Mission by:

- Continuing the shift toward a consumer-centric health organization with multiple, convenient access points
- Digitally enabling, simplifying, and personalizing the health experience
- Engaging and initiating strategic partnerships along the care continuum
- Creating an integrated scientific wellness, clinical research and genomics program that is nationally recognized for breakthrough advances
- Utilizing insights and value from data to drive strategic transformation
- Activating the voice and presence of the System nationally to improve health policies

In support of our Strategic Plan, we will manage and deploy our resources to their highest and best use to sustain our Mission by:

- Allocating capital in support of our Strategic Plan
- Introducing more rigor and financial discipline in our Capital allocation process with an emphasis on our Return-on-Invested Capital (ROIC)
- Diversifying our care delivery and payment models to capture more value and align with community and industry trends
- Developing premium assets and services where we have unique advantages and/or leverage disruptive technologies

- Unlocking the value in our non-core assets through divestitures or pursuing structures and partnerships
- Continuing to safeguard our financial assets through attainment of further efficiencies, increased transparency and ensure full integration with our balance sheet

Consumerization

Extending our Ambulatory network

We are expanding our ambulatory care network through organic and inorganic growth strategies, new outpatient centers, corporate development activities, and strategic partnerships. Our ambulatory network is comprised of 32 ambulatory care centers, 39 imaging centers, 55 urgent care centers, 34 retail clinics, and over 700 primary and specialty clinics. We believe ambulatory networks offer advantages to patients and physicians, including greater affordability, predictability, flexibility, and convenience. Due to advancements in medical technology, the lower cost structure and greater efficiencies that are attainable in a specialized outpatient facility. We believe the volume and complexity of surgical cases performed in an outpatient setting will continue to steadily increase. We are evolving our care model for the future by providing patients with consumer-oriented, lower cost options for virtual and at-home care that provide greater ease of access.

Population Health

Transforming care and improving population outcomes

Population Health models and initiatives form a vital pillar in achieving our strategic plan of creating healthier communities, together. Our goal is to maximize the health outcomes of the people in our defined populations and communities through the design, delivery, and coordination of affordable quality health care. In 2017, our health plan served over one million patients and was one of only 23 plans nationally to achieve 5-Star Medicare Health Plan Quality Status which represents our commitment to value-based care delivery. We are focused on the social determinants of health, including access to care and services, reliable transportation, housing, education, and nutrition, and by building partnerships that involve care management, housing, community services, and increased access.

Scientific Wellness

Aligning biomedical innovation with real world clinical practice

We are pioneering predictive modeling through our research affiliate, the Institute for Systems Biology, a biomedical research organization comprised of a cross-disciplinary team of scientists with expertise in biology, technology, computer science, engineering, and bioinformatics. The ISB consists of 185 full-time staff from 30 countries, produced over 1,300 research publications since 2000, ranked 4th in the world for research impact, and has generated over \$364 million in grants and contracts revenue. Through ISB, we have formed partnerships, most recently with Seattle startup Arivale to explore how data-driven lifestyle coaching can prevent the advancement of Alzheimer's or reverse early symptoms of the disease. We seek to take a systems-driven approach to optimize health and predict and prevent disease, and enable a sustainable environment in the communities we serve and nationally.

Data and Digital Innovation

Rapid proliferation of data, advanced analytics and digital technology

We are investing in a fully integrated patient system to leverage technology that allows us to operate more effectively across regions and ministries, surfaces and socializes best practices, and identifies trends and opportunities across the system. We expect cost savings as standardizations continue across all ministries and anticipate these improvements will also allow our caregivers to serve our patients more efficiently. The

renewal and expansion of our core platform represents our dedication to enhancing the patient experience across the continuum of care.

Bringing together technology and digital innovation with health care delivery

We work to bring health care into the digital and consumer age with the goal of better serving patients and consumers by delivering care on their terms. We believe digital engagement increases the patient’s access to care by creating a continuous relationship with patients between episodes of care and expanding beyond our existing markets. We offer the following direct-to-customer products to engage patients:

- Express Care is a digital platform that enables on-demand patient access to Express Care retail clinics, telehealth, or at-home visits through the web or mobile apps
- The Circle™ is a mobile women’s health platform that delivers relevant content, products and services on pregnancy and pediatrics
- Xealth™ allows physicians to prescribe digital content, apps and services to patients through electronic medical records
- Optimal Aging™ provides seniors with affordable access to non-clinical services such as transportation, meals, home care and other lifestyle necessities

“Growth through access, convenience, and personalization is a great first step in digitally enabling our health system to deliver modernized, frictionless care to our patients.”
-Aaron Martin, Executive Vice President and Chief Digital Officer

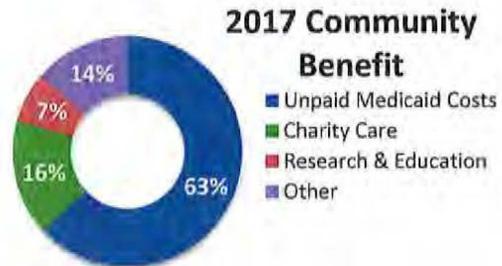


Community Benefit

Sustaining our Mission by investing in our communities

We have a deep rooted history of reaching out to those in need, working to bring hope, health and healing to those we serve. As a faith-based, not-for-profit health and social services system, our commitment to community is realized, in part, through community programs and services that:

- Promote health and well-being
- Extend care to those poor and vulnerable who lack coverage from the U.S. healthcare finance system
- Support health professions education aimed at increasing the health care workforce
- Provide free and discounted medical care through our Financial Assistance Program



In each of the past two years, we have invested over \$1.6 billion per year in community benefit demonstrating our commitment to the communities we serve. In an environment of decreased reimbursement for government sponsored medical care, Medicaid shortfall, after accounting for government reimbursement, was \$1.0 billion, the total community benefit in both 2017 and 2016. We recognize that health begins in our homes, schools, workplaces, neighborhood, and communities.

Introduction to Management's Discussion and Analysis

Management's discussion and analysis provides additional narrative explanation of the financial condition, operational results and cash flow of the System to assist in understanding the combined financial statements. The following information should be read in conjunction with the audited combined financial statements of the System, including the notes thereto, and the report of KPMG LLP, independent auditors.

Leadership in the Health Care Industry

We announced the selection of **Venkat Bhamidipati**, formerly of Microsoft, as Executive Vice President and Chief Financial Officer in 2017 overseeing finance, as well as real estate, treasury, supply chain, and revenue cycle.

Principles of Consolidation

The audited combined financial information as of and for the twelve-month period ended December 31, 2017, presented below, has been derived by the System's management from the audited financial information. The unaudited pro forma combined financial information presented below of the System for the twelve-month period ended December 31, 2016 have been derived by combining the consolidated year-to-date results of Providence Health & Services and St. Joseph Health assuming that operations of the two organizations were combined as of January 1, 2016. Acquisition-related adjustments are included in the results as of the date of acquisition of July 1, 2016.

Results of Operations

Consolidated Statements of Operations				
DATA PRESENTED YEAR TO DATE; PRESENTED IN MILLIONS	12-31-17	Pro Forma 12-31-16	VARIANCE	VARIANCE %
Net Patient Service Revenue	17,867	17,296	571	3%
Premium and Capitation Revenue	4,079	3,773	306	8%
Other Revenue	1,217	1,088	129	12%
Total Operating Revenue	23,163	22,157	1,006	5%
Salaries, Wages and Other	21,853	21,111	742	4%
Depreciation	1,038	1,036	2	0%
Interest and Amortization	269	265	4	2%
Total Operating Expenses	23,160	22,412	748	3%
Excess (Deficit) of Revenues Over Expenses from Operations	3	(255)	258	(101%)
Net Non-operating (Losses) Gains	777	378	399	106%
Contributions from Affiliations and loss on extinguishment of debt	0	5,108	(5,108)	(100%)
Excess of Revenues Over Expenses	780	5,231	(4,451)	(85%)
Operating EBIDA	1,310	1,046	264	25%

Consolidated Balance Sheets

PRESENTED IN MILLIONS	12-31-17	12-31-16	VARIANCE	VARIANCE %
ASSETS				
<u>Current Assets:</u>				
Cash and Cash Equivalents	1,371	1,000	371	37%
Short-term Investments	414	657	(243)	(37%)
Accounts Receivable, Net	2,222	2,206	16	1%
Supplies Inventory at Cost	277	279	(2)	(1%)
Other Current Assets	1,157	1,169	(12)	(1%)
Current Portion of Funds Held by Trustee	66	109	(43)	(39%)
Total Current Assets	5,507	5,420	87	2%
<u>Assets Whose Use Is Limited:</u>				
Long-term Investments	9,526	8,341	1,185	14%
Gift, Annuity, Trust and Other	181	131	50	38%
Funds Held by Trustee	279	259	20	8%
Total Assets Whose Use Is Limited	9,986	8,731	1,255	14%
Property, Plant & Equipment, Net	10,955	11,022	(67)	(1%)
Total Other Assets	1,197	1,118	79	7%
Total Assets	27,645	26,291	1,354	5%
LIABILITIES AND NET ASSETS				
<u>Current Liabilities:</u>				
Master Trust Debt classified as Short-term	57	153	(96)	(63%)
Accounts Payable	684	632	52	8%
Accrued Compensation	1,111	1,104	7	1%
Payable to Contractual Agencies	122	197	(75)	(38%)
Other Current Liabilities	2,169	1,666	503	30%
Current Portion of Long-term Debt	78	200	(122)	(61%)
Total Current Liabilities	4,221	3,952	269	7%
Long-term Debt, Net of Current Portion	6,485	6,396	89	1%
Other Long-term Liabilities	2,193	2,147	46	2%
Total Liabilities	12,899	12,495	404	3%
<u>Net Assets:</u>				
Unrestricted	13,545	12,760	785	6%
Temporarily Restricted	958	816	142	17%
Permanently Restricted	243	220	23	10%
Total Net Assets	14,746	13,796	950	7%
Total Liabilities and Net Assets	27,645	26,291	1,354	5%

Operating income was \$3 million for the year ended December 31, 2017, compared with an operating loss of \$255 million in the prior year. Operating earnings before interest, depreciation and amortization (“EBIDA”) increased to \$1.3 billion for the year ended December 31, 2017, compared with \$1 billion over the prior year. Operating EBIDA includes a \$133 million gain related to the sale of Pathology Associates Medical Laboratories, LLC in 2017 which balanced a \$90 million decline related to approval delays for the managed care portion of the California provider tax program. Excluding these items, operating EBIDA increased to \$1.2 billion, or 21 percent for the year ended December 2017, compared with \$956 million over the prior year, primarily driven by expense reduction efforts and higher volumes. The table below provides key financial indicators for the periods indicated:

DATA PRESENTED YEAR TO DATE; \$ FIGURES PRESENTED IN MILLIONS	12-31-17	<i>Pro Forma</i> 12-31-16	VARIANCE	VARIANCE %
Operating Margin %	0.0	(1.2)	1.2	100%
Operating EBIDA Margin %	5.7	4.7	1.0	21%
Total Community Benefit	1,601	1,632	(31)	(2%)
Net Service Revenue/Case Mix Adjusted Admits	11,652	11,817	(165)	(1%)
Expense/Case Mix Adjusted Admits	11,650	11,976	(326)	(3%)
Full-time Equivalents (thousands)	103	102	1	1%

Volume Trends

The System’s core strategy of delivering outstanding, affordable health care led to higher volumes in 2017 compared with the prior year. This growth was largely driven by outpatient activity and higher acuity within the acute setting as measured by case mix index which increased four percent for the year ended December 31, 2017, compared with the prior year. Outpatient visits grew five percent, primarily driven by an eight percent increase in surgeries including 13 percent growth in the outpatient setting for the year ended December 31, 2017. The table below provides key volume indicators for the periods indicated:

DATA PRESENTED YEAR TO DATE; IN THOUSANDS UNLESS NOTED	12-31-17	<i>Pro Forma</i> 12-31-16	VARIANCE	VARIANCE %
Inpatient Admissions	522	526	(4)	(1%)
Acute Adjusted Admissions	1,002	989	13	1%
Acute Patient Days	2,420	2,387	33	1%
Long-term Patient Days	399	400	(1)	0%
Outpatient Visits (incl. Physicians)	25,648	24,352	1,296	5%
Emergency Room Visits	2,119	2,124	(5)	0%
Total Surgeries	613	567	46	8%
Acute Average Daily Census	6,631	6,522	109	2%
Providence Health Plan Members	648	639	9	1%

The Providence Health Plan enrollment grew one percent compared with the prior year. Connected lives member months, a measure of coverage for insured members, were 8 million for the Providence Health Plan, an increase of 2 percent for the year ended December 31, 2017, compared with the prior year.

Operating Revenue

Operating revenue for the year ended December 31, 2017 was \$23 billion, an increase of five percent compared with the prior year due primarily to volumes growth. Capitation and premium revenue, representing 18 percent of total operating revenue, grew eight percent during the year ended December 31, 2017, compared with the prior year. The System's operating revenue share by geographic region for the year ended December 31, 2017 is shown in the table below for the periods indicated:

REGIONAL OPERATING REVENUE SHARE	12-31-17	Pro Forma 12-31-16	VARIANCE
Alaska	4%	4%	0%
Swedish	11%	12%	(1%)
Washington and Montana	20%	20%	0%
Oregon	21%	20%	1%
Northern California	6%	6%	0%
Southern California	29%	29%	0%
Texas	6%	7%	(1%)
Other	3%	2%	1%

The System's operating revenue share by line of business for the year ended December 31, 2017 is shown in the table below for the periods indicated:

SEGMENT OPERATING REVENUE SHARE	12-31-17	Pro Forma 12-31-16	VARIANCE
Hospitals	71%	72%	(1%)
Health Plans and Accountable Care	12%	11%	1%
Physician and Outpatient Activities	12%	12%	0%
Continuum Services	5%	5%	0%

Net patient revenue per case mix adjusted admissions declined one percent for the year ended December 31, 2017, on a reported basis; however, grew 2 percent when adjusting for the timing of the provider fee in California despite lower commercial mix. The System's net patient revenue by payor mix is shown in the table below for the periods indicated:

PAYOR NET PATIENT REVENUE SHARE	12-31-17	Pro Forma 12-31-16	VARIANCE
Commercial	50%	51%	(1%)
Medicare	33%	32%	1%
Medicaid	14%	15%	(1%)
Self-pay and Other	3%	2%	1%

Operating Expenses

Operating expenses for the year ended December 31, 2017 were \$23 billion, an increase of three percent compared with the prior year, driven mainly by costs to serve higher volumes. The increase was nearly two points lower than revenue growth due to productivity improvements and the realization of synergies from the System's affiliation in 2016. Salaries and wages expense increased four percent for the year ended December 31, 2017, compared with the prior year, driven by full-time equivalent growth, and higher wage rates and benefit costs, while supplies expense increased four percent from higher volumes, pharmaceutical spend, and a shift into procedures leveraging new technologies.

Non-Operating Income

Non-operating income is primarily comprised of investment gains and losses, pension settlement costs and innovation projects and expense. Non-operating income included a combined net gain of \$5 billion in 2016, from affiliation and subsequent debt restructuring. Excluding the impact of gains related to the affiliation and debt refinancing, non-operating income increased to \$777 million for the year ended December 31, 2017, compared with \$378 million in the prior year, driven by strong investment performance.

Liquidity and Capital Resources

Financial Ratios

The table below includes the System's financial ratios for the periods indicated:

DATA PRESENTED YEAR TO DATE; \$ FIGURES PRESENTED IN MILLIONS	12-31-17	<i>Pro Forma</i> 12-31-16	VARIANCE
Debt to Capitalization %	32.6	33.9	(1.3)
Debt Service Coverage	3.3	2.7	0.6
Cash to Debt Ratio %	172.9	148.8	24.1
Operating Cash Flow Margin %	5.7	4.7	1.0
Cash to Comprehensive Debt %	114.4	98.3	16.1
Debt to Cash Flow	3.1	4.6	(1.5)
Cushion Ratio	29	25	4
Maximum Annual Debt Service	384	389	(5)
Comprehensive Debt to Capitalization %	42.2	43.7	(1.5)
Cash to Total Net Asset Ratio	0.84	0.76	0.08

Unrestricted Cash and Investments

Unrestricted cash reserves totaled \$11.3 billion as of December 31, 2017 compared to \$9.7 billion in the prior year driven primarily by investment gains, partially offset by payments related to pension obligations, debt service costs, and capital expenditures. Days of cash on hand, a measure of cash in relation to monthly operating expenses, was 187 days at December 31, 2017, an improvement of 19 days compared with the prior year, primarily driven by increases in investment income.

Credit Agency Ratings

The System received affirmation on the following ratings from the three national credit rating agencies conducted during their annual review in 2017 and issued the following credit ratings:

- Fitch: "AA-"
- Standard and Poor's: "AA-"
- Moody's: "Aa3"

Subsequent Events

Plan of Finance

In February 2018, the System closed on its 2018 plan of finance which included \$350 million of taxable debt and \$142 million in fixed rate tax-exempt debt for the System and its affiliates. The proceeds will be used primarily to refinance existing bonds and draws on existing lines of credit. The bonds also finance a small portion of new debt and prior series of debt.

Financial Performance Crosswalk

As noted previously, certain results discussed in this document are presented on a pro forma basis for the System. The tables below represent a comparison of the combined pro forma data for the year ended December 31, 2016 versus the audited results of the System, which includes St. Joseph Health financial results from the effective date of the affiliation of July 1, 2016. The difference represents activity from January 1, 2016 to June 30, 2016, which was prior to the effective date of the affiliation.

Statements of Operations DATA PRESENTED YEAR TO DATE, \$ FIGURES PRESENTED IN MILLIONS	12-31-2016	
	Pro Forma	Audited
Net Patient Revenue	17,296	14,769
Premium and Capitation Revenue	3,773	3,105
Other Revenue	1,088	1,005
Total Revenue	22,157	18,879
Salaries and Wages	8,926	7,788
Depreciation	1,036	851
Interest and Amortization	265	215
Other Expenses	12,185	10,274
Total Operating Expenses	22,412	19,128
Excess of Revenues Over Expenses from Operations	(255)	(249)
Net Non-operating (Losses) Gains	5,486	5,480
Excess of Revenues Over Expenses	5,231	5,231

Obligated Group

During the year ended December 31, 2017, the audited combined net operating revenue and total assets attributable to the Obligated Group Members were approximately 83.0% and 88.2%, respectively, of the System totals. For the year ended December 31, 2016, the unaudited pro forma combined net operating revenues and total assets attributable to the Obligated Group Members were approximately 78.8% and 90.5%, respectively, of the Systems totals. The following exhibits are voluntary supplemental information on the Obligated Group Members.

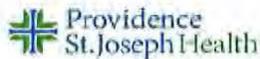


EXHIBIT A.1 - SUMMARY AUDITED AND UNAUDITED PRO FORMA COMBINED STATEMENTS OF OPERATION

	Ended December 31, 2017		<i>Pro Forma</i>	
	(in 000's of dollars)		Ended December 31, 2016	
	Consolidated	Obligated	Consolidated	Obligated
Operating Revenue:				
Net Service Revenue	\$ 17,866,609	\$ 17,387,036	\$ 17,296,033	\$ 15,634,509
Premium and Capitation Revenue	4,079,290	772,317	3,773,289	920,446
Other Operating Revenue	1,217,346	1,071,744	1,087,711	906,984
Net Operating Revenues	23,163,245	19,231,097	22,157,033	17,461,939
Operating Expenses:				
Salaries, Wages and Benefits	11,464,879	10,391,082	11,028,633	9,411,158
Supplies	3,389,917	3,194,180	3,260,563	2,811,508
Depreciation Expense	1,037,984	974,623	1,036,273	873,016
Interest and Amortization	269,042	257,793	265,036	225,025
Other Expenses	6,998,330	3,826,726	6,821,429	3,964,044
Total Operating Expenses	23,160,152	18,644,404	22,411,934	17,284,751
Excess (Deficit) of Rev Over Exp from Operations	3,093	586,693	(254,901)	177,188
Net Non-operating (Losses) Gains	776,859	769,305	5,484,963	81,254
Excess of Revenue Over Expenses	\$ 779,952	\$ 1,355,998	\$ 5,230,062	\$ 258,442

EXHIBIT A.2 - SUMMARY AUDITED AND UNAUDITED PRO FORMA COMBINED STATEMENTS OF CASH FLOW

	Ended December 31, 2017		<i>Pro Forma</i>	
	(in 000's of dollars)		Ended December 31, 2016	
	Consolidated	Obligated	Consolidated	Obligated
Net cash provided by (used in) operating activities	\$ 1,268,066	\$ 2,314,246	\$ 1,006,944	\$ 1,169,294
Net cash provided by (used in) investing activities	(1,027,427)	(814,554)	(1,195,392)	(929,188)
Net cash provided by (used in) financing activities	130,363	(1,263,649)	303,187	(134,743)
Increase in cash and cash equivalents	371,002	236,043	114,739	105,363
Cash and cash equivalents, beginning of period	1,000,187	550,883	885,448	445,520
Cash and cash equivalents, end of period	\$ 1,371,189	\$ 786,926	\$ 1,000,187	\$ 550,883

EXHIBIT A.3 - SUMMARY AUDITED AND UNAUDITED PRO FORMA NET PATIENT REVENUE PAYOR MIX

	Ended December 31, 2017		<i>Pro Forma</i>	
	(in 000's of dollars)		Ended December 31, 2016	
	Consolidated	Obligated	Consolidated	Obligated
Commercial	50%	50%	51%	48%
Medicare	33%	33%	32%	33%
Medicaid	14%	15%	15%	16%
Self-pay and Other	3%	2%	2%	3%

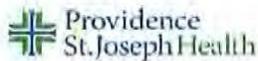


EXHIBIT A.4 - SUMMARY AUDITED AND UNAUDITED COMBINED BALANCE SHEETS

	As of December 31, 2017		As of December 31, 2016	
	(in 000's of dollars)		(in 000's of dollars)	
	Consolidated	Obligated	Consolidated	Obligated
<u>Current Assets:</u>				
Cash and Cash Equivalents	\$ 1,371,189	\$ 786,926	\$ 1,000,187	\$ 550,883
Short-term Management Designated Investments	413,700	254,383	657,392	487,902
Accounts Receivable, Net	2,221,520	2,147,724	2,206,313	2,122,934
Other Current Assets	1,434,329	1,373,457	1,447,967	1,644,012
CP of Assets-Use is Limited	66,242	1,532	108,839	3,476
Total Current Assets	5,506,980	4,564,022	5,420,698	4,809,207
<u>Assets Whose Use is Limited:</u>				
Management Designated Cash and Investments	9,525,490	7,168,794	8,190,080	6,525,727
Funds Held by Trustee, Gift Annuity, and Other	460,361	411,613	541,030	294,214
Assets Whose Use is Limited	9,985,851	7,580,407	8,731,110	6,819,941
Property Plant Equipment Net	10,955,120	10,495,562	11,022,371	10,561,025
Total Other Long-term Assets	1,196,723	1,732,368	1,117,521	1,594,830
Total Assets	\$ 27,644,674	\$ 24,372,359	\$ 26,291,700	\$ 23,785,003
<u>Current Liabilities:</u>				
Short-term Debt	\$ 56,676	\$ 56,675	\$ 153,350	\$ 153,350
Accounts Payable	684,382	623,661	632,240	506,281
Accrued Compensation	1,110,682	1,033,090	1,104,376	1,025,646
Other Current Liabilities	2,369,876	1,699,368	2,062,386	1,483,963
Total Current Liabilities	4,221,616	3,412,794	3,952,352	3,169,240
Long Term Debt	6,484,528	6,457,366	6,396,089	6,376,495
Total Other Long-term Liabilities	2,193,453	1,562,861	2,148,641	1,653,888
Total Liabilities	12,899,597	11,433,021	12,497,082	11,199,623
<u>Net Assets:</u>				
Unrestricted	13,544,700	12,177,980	12,759,330	11,921,608
Restricted Net Assets	1,200,377	761,358	1,035,288	663,772
Total Net Assets	14,745,077	12,939,338	13,794,618	12,585,380
Total Liabilities and Net Assets	\$ 27,644,674	\$ 24,372,359	\$ 26,291,700	\$ 23,785,003

EXHIBIT A.5 - KEY PERFORMANCE METRICS

	Ended December 31, 2017		<i>Pro Forma</i> Ended December 31, 2016	
	Consolidated	Obligated	Consolidated	Obligated
Total Acute Admissions	522,153	516,227	526,342	520,368
Total Acute Patient Days	2,420,196	2,391,407	2,387,172	2,358,776
Acute Outpatient Visits	12,353,677	11,759,499	12,184,611	11,598,565
Primary Care Visits	12,127,920	8,345,993	11,193,978	7,703,288
Inpatient Surgeries	226,149	221,487	224,287	219,663
Outpatient Surgeries	386,881	336,140	342,323	297,426
Long-Term Care Patient Days	398,917	387,459	400,031	388,541
Home Health Visits	1,166,858	793,982	972,973	662,054
Hospice Days	869,064	611,544	835,183	587,703
Housing and Assisted Living Days	612,698	248,169	579,503	234,724
Health Plan Members	818,640	n/a	825,331	n/a
Total Average Daily Census	6,631	6,552	6,522	6,445
Total Acute Licensed Beds	11,817	11,747	11,915	11,844
FTEs	103,058	93,326	101,846	92,229



EXHIBIT B.1 - SUMMARY AUDITED COMBINING STATEMENTS OF OPERATIONS BY REGION

	Ended December 31, 2017								
	(in 000's of dollars)								
	Alaska	Swedish	Washington/ Montana	Oregon	Northern California	Southern California	Texas	Other/ Eliminations	Consolidated
Operating Revenue:									
Net Service Revenue	\$ 817,706	\$ 2,515,900	\$ 4,160,401	\$ 2,436,046	\$ 1,303,771	\$ 5,427,279	\$ 840,490	\$ 365,016	\$ 17,866,609
Premium and Capitation Revenue	0	0	147,187	2,130,582	57,321	1,129,600	565,894	48,706	4,079,290
Other Operating Revenue	58,597	133,740	221,781	255,367	45,747	215,769	67,679	218,666	1,217,346
Net Operating Revenues	876,303	2,649,640	4,529,369	4,821,995	1,406,839	6,772,648	1,474,063	632,388	23,163,245
Operating Expenses:									
Salaries, Wages and Benefits	331,122	1,255,344	2,047,093	1,556,464	663,314	2,806,823	516,049	2,288,670	11,464,879
Supplies	110,938	440,805	744,140	470,519	194,994	983,151	192,158	253,212	3,389,917
Depreciation Expense	49,105	113,130	134,587	111,250	56,136	280,948	45,273	247,555	1,037,984
Interest and Amortization	11,848	46,551	52,021	8,001	14,695	92,482	5,730	37,714	269,042
Other Expenses	285,807	816,605	1,527,013	2,590,732	450,292	2,786,618	663,692	(2,122,429)	6,998,330
Total Operating Expenses	788,820	2,672,435	4,504,854	4,736,966	1,379,431	6,950,022	1,422,902	704,722	23,160,152
Excess (Deficit) of Revenue Over Expenses from Operations	87,483	(22,795)	24,515	85,029	27,408	(177,374)	51,161	(72,334)	3,093
Net Non-operating (Losses) Gains	52,897	62,000	71,779	125,553	45,142	307,334	10,220	101,934	776,859
Excess of Revenue Over Expenses	\$ 140,380	\$ 39,205	\$ 96,294	\$ 210,582	\$ 72,550	\$ 129,960	\$ 61,381	\$ 29,600	\$ 779,952



EXHIBIT B.2 - SUMMARY AUDITED COMBINING BALANCE SHEETS BY REGION

	As of December 31, 2017 (in 000's of dollars)								
	Alaska	Swedish	Washington/ Montana	Oregon	Northern California	Southern California	Texas	Other/ Eliminations	Consolidated
Current Assets:									
Cash and Cash Equivalents	\$ 172,414	\$ 85,792	\$ 192,357	\$ 98,938	\$ 34,153	\$ 426,649	\$ 127,832	\$ 233,054	\$ 1,371,189
Short-term Management Designated Investments	0	0	0	0	3,886	17,072	1,751	390,991	413,700
Accounts Receivable, Net	129,985	332,753	504,673	262,072	157,389	684,480	137,388	12,780	2,221,520
Other Current Assets	367,048	167,459	522,578	494,068	90,966	(215,097)	74,202	(66,895)	1,434,329
Current Portion of Assets-Use is Limited	0	0	0	0	0	0	0	66,242	66,242
Total Current Assets	669,447	586,004	1,219,608	855,078	286,394	913,104	341,173	636,172	5,506,980
Assets Whose Use is Limited:									
Management Designated Cash and Investments	570,509	565,955	754,354	1,914,016	429,130	2,812,208	129,126	2,350,192	9,525,490
Funds Held by Trustee, Gift Annuity, and Other	282	14,453	4,890	136,679	14,317	43,419	3,939	242,382	460,361
Assets Whose Use is Limited	570,791	580,408	759,244	2,050,695	443,447	2,855,627	133,065	2,592,574	9,985,851
Property Plant Equipment Net	491,645	1,343,130	1,719,598	1,082,050	648,258	3,734,530	409,364	1,526,545	10,955,120
Total Other Long-term Assets	24,009	112,668	198,605	29,446	13,725	480,184	55,184	282,902	1,196,723
Total Assets	\$ 1,755,892	\$ 2,622,210	\$ 3,897,055	\$ 4,017,269	\$ 1,391,824	\$ 7,983,445	\$ 938,786	\$ 5,038,193	\$ 27,644,674
Current Liabilities:									
Short-term Debt	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 56,676	\$ 56,676
Accounts Payable	14,640	53,475	96,666	79,169	37,153	211,828	22,123	169,328	684,382
Accrued Compensation	29,882	85,817	170,726	127,426	47,975	286,559	40,628	321,669	1,110,682
Other Current Liabilities	7,341	142,561	352,550	409,666	147,357	674,285	78,489	557,627	2,369,876
Total Current Liabilities	51,863	281,853	619,942	616,261	232,485	1,172,672	141,240	1,105,300	4,221,616
Long Term Debt	259,066	1,034,008	1,185,976	210,619	360,810	2,133,335	150,191	1,150,523	6,484,528
Total Other Long-term Liabilities	22,889	436,712	38,671	40,279	7,444	188,987	36,664	1,421,807	2,193,453
Total Liabilities	333,818	1,752,573	1,844,589	867,159	600,739	3,494,994	328,095	3,677,630	12,899,597
Net Assets:									
Unrestricted	1,407,926	791,576	1,988,958	2,984,100	733,280	3,836,659	574,543	1,227,658	13,544,700
Restricted Net Assets	14,148	78,061	63,508	166,010	57,805	651,792	36,148	132,905	1,200,377
Total Net Assets	1,422,074	869,637	2,052,466	3,150,110	791,085	4,488,451	610,691	1,360,563	14,745,077
Total Liabilities and Net Assets	\$ 1,755,892	\$ 2,622,210	\$ 3,897,055	\$ 4,017,269	\$ 1,391,824	\$ 7,983,445	\$ 938,786	\$ 5,038,193	\$ 27,644,674

EXHIBIT B.3 - KEY PERFORMANCE METRICS BY REGION

As of December 31, 2017

	Alaska	Swedish	Washington/ Montana	Oregon	Northern California	Southern California	Texas	Consolidated
Total Acute Admissions	16,926	67,237	129,574	64,646	29,489	188,961	25,320	522,153
Total Acute Patient Days	111,385	300,041	638,338	301,536	157,123	781,465	130,307	2,420,196
Acute Outpatient Visits	457,418	756,935	2,816,944	3,480,608	728,962	3,573,255	539,556	12,353,677
Primary Care Visits	129,306	1,889,629	3,724,101	2,292,127	446,427	3,255,716	390,614	12,127,920
Inpatient Surgeries	8,842	32,047	59,729	31,125	8,361	77,716	8,329	226,149
Outpatient Surgeries	11,774	51,890	108,433	60,872	18,359	117,719	17,834	386,881
Long-Term Care Patient Days	58,571	n/a	14,214	44,542	n/a	82,496	11,458	398,917
Home Health Visits	13,740	n/a	27,091	303,835	53,188	396,247	n/a	1,166,858
Hospice Days	19,151	n/a	n/a	185,458	62,769	116,252	51,629	869,064
Housing and Assisted Living Days	28,936	n/a	28,137	144,528	n/a	n/a	n/a	612,698
Health Plan Members	n/a	n/a	n/a	647,781	n/a	n/a	170,859	818,640
Total Average Daily Census	305	822	1,749	826	430	2,141	357	6,631
Total Acute Licensed Beds	426	1,576	2,771	1,484	(1)	3,909	891	11,817
FTEs	3,647	10,777	20,676	15,856	4,827	27,151	5,405	103,058



PROVIDENCE ST. JOSEPH HEALTH
Combined Financial Statements
December 31, 2017 and 2016
(With Independent Auditors' Report Thereon)



KPMG LLP
Suite 2900
1918 Eighth Avenue
Seattle, WA 98101

Independent Auditors' Report

The Board of Directors
Providence St. Joseph Health:

Report on the Financial Statements

We have audited the accompanying combined financial statements of Providence St. Joseph Health, which comprise the combined balance sheets as of December 31, 2017 and 2016, and the related combined statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the financial position of St. Joseph Health as of December 31, 2017 and 2016, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.



Other Matter

Our audit was conducted for the purpose of forming an opinion on the combined financial statements as a whole. The Obligated Group Combining Balance Sheets and Statements of Operations Information included on pages 33 and 34 is presented for purposes of additional analysis and is not a required part of the combined financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the combined financial statements. The information has been subjected to the auditing procedures applied in the audit of the combined financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the combined financial statements or to the combined financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the combined financial statements as a whole.

KPMG LLP

Seattle, Washington
March 7, 2018

PROVIDENCE ST. JOSEPH HEALTH

Combined Balance Sheets

December 31, 2017 and 2016

(In millions of dollars)

Assets	2017	2016
Current assets:		
Cash and cash equivalents	\$ 1,371	1,000
Accounts receivable, less allowance for bad debts of \$227 in 2017 and \$271 in 2016	2,222	2,206
Supplies inventory	277	279
Other current assets	1,157	1,169
Current portion of assets whose use is limited	480	766
Total current assets	5,507	5,420
Assets whose use is limited	9,986	8,731
Property, plant, and equipment, net	10,955	11,022
Other assets	1,197	1,118
Total assets	\$ 27,645	26,291
Liabilities and Net Assets		
Current liabilities:		
Current portion of long-term debt	\$ 78	200
Master trust debt classified as short-term	57	153
Accounts payable	684	632
Accrued compensation	1,111	1,104
Other current liabilities	2,291	1,863
Total current liabilities	4,221	3,952
Long-term debt, net of current portion	6,485	6,396
Pension benefit obligation	1,054	1,120
Other liabilities	1,139	1,027
Total liabilities	12,899	12,495
Net assets:		
Unrestricted:		
Controlling interest	13,366	12,560
Noncontrolling interest	179	200
Temporarily restricted	958	816
Permanently restricted	243	220
Total net assets	14,746	13,796
Total liabilities and net assets	\$ 27,645	26,291

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH
 Combined Statements of Operations
 Years ended December 31, 2017 and 2016
 (In millions of dollars)

	<u>2017</u>	<u>2016</u>
Operating revenues:		
Net patient service revenues	\$ 18,136	14,972
Provision for bad debts	(269)	(203)
Net patient service revenues less provision for bad debts	17,867	14,769
Premium revenues	2,745	2,240
Capitation revenues	1,334	865
Other revenues	1,217	1,005
Total operating revenues	<u>23,163</u>	<u>18,879</u>
Operating expenses:		
Salaries and benefits	11,464	9,599
Supplies	3,390	2,788
Purchased healthcare services	2,539	1,917
Interest, depreciation, and amortization	1,307	1,066
Purchased services, professional fees, and other	4,460	3,758
Total operating expenses	<u>23,160</u>	<u>19,128</u>
Excess (deficit) of revenues over expenses from operations	<u>3</u>	<u>(249)</u>
Net nonoperating gains (losses):		
Contributions from affiliations	—	5,167
Loss on extinguishment of debt	—	(60)
Investment income, net	882	403
Other	(105)	(30)
Total net nonoperating gains	<u>777</u>	<u>5,480</u>
Excess of revenues over expenses	<u>\$ 780</u>	<u>5,231</u>

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH
 Combined Statements of Changes in Net Assets
 Years ended December 31, 2017 and 2016
 (In millions of dollars)

	Unrestricted		Temporarily restricted	Permanently restricted	Total net assets
	controlling interest	noncontrolling interest			
Balance, December 31, 2015	\$ 7,542	45	325	124	8,036
Excess of revenues over expenses	5,093	138	—	—	5,231
Restricted contributions from affiliations	—	—	405	91	496
Contributions, grants, and other	(13)	17	145	5	154
Net assets released from restriction	19	—	(59)	—	(40)
Pension related changes	(81)	—	—	—	(81)
Increase in net assets	<u>5,018</u>	<u>155</u>	<u>491</u>	<u>96</u>	<u>5,760</u>
Balance, December 31, 2016	<u>12,560</u>	<u>200</u>	<u>816</u>	<u>220</u>	<u>13,796</u>
Excess of revenues over expenses	747	33	—	—	780
Contributions, grants, and other	(43)	(54)	222	23	148
Net assets released from restriction	44	—	(80)	—	(36)
Pension related changes	58	—	—	—	58
Increase (decrease) in net assets	<u>806</u>	<u>(21)</u>	<u>142</u>	<u>23</u>	<u>950</u>
Balance, December 31, 2017	<u>\$ 13,366</u>	<u>179</u>	<u>958</u>	<u>243</u>	<u>14,746</u>

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Combined Statements of Cash Flows

Years ended December 31, 2017 and 2016

(In millions of dollars)

	2017	2016
Cash flows from operating activities:		
Increase in net assets	\$ 950	5,760
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Contributions from affiliations	—	(5,663)
Gain on divestiture	(133)	—
Depreciation and amortization	1,057	860
Provision for bad debt	269	203
Loss on extinguishment of debt	—	60
Restricted contributions and investment income received	(245)	(150)
Net realized and unrealized gains on investments	(761)	(316)
Changes in certain current assets and current liabilities	166	13
Change in certain long-term assets and liabilities	(35)	26
Net cash provided by operating activities	1,268	793
Cash flows from investing activities:		
Property, plant, and equipment additions	(1,009)	(967)
Sales of trading securities, net	18	68
Purchases of alternative investments and commingled funds	(551)	(466)
Proceeds from sales of alternative investments and commingled funds	367	153
Cash acquired through affiliation and divestiture activities, net of cash paid	114	367
Other investing activities	34	49
Net cash used in investing activities	(1,027)	(796)
Cash flows from financing activities:		
Proceeds from restricted contributions and restricted income	245	150
Debt borrowings	376	3,606
Debt payments	(483)	(3,474)
Other financing activities	(8)	(8)
Net cash provided by financing activities	130	274
Increase in cash and cash equivalents	371	271
Cash and cash equivalents, beginning of year	1,000	729
Cash and cash equivalents, end of year	\$ 1,371	1,000
Supplemental disclosure of cash flow information:		
Cash paid for interest (net of amounts capitalized)	\$ 245	191

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

(1) Basis of Presentation and Significant Accounting Policies

(a) Reporting Entity

Providence St. Joseph Health (the Health System) is a Washington nonprofit corporation that became the sole corporate member of Providence Health & Services (PHS) and the St. Joseph Health System (SJHS) as of July 1, 2016. PHS, a Washington nonprofit corporation, is a Catholic healthcare system sponsored by the public juridic person, Providence Ministries. SJHS, a California nonprofit public benefit corporation, is a Catholic healthcare system sponsored by the public juridic person, St. Joseph Health Ministry. The business combination of PHS and SJHS, through the alignment under the Health System, qualified for acquisition accounting with PHS as the acquirer of SJHS.

The Health System seeks to improve the health of the communities it serves, especially the poor and vulnerable. The Health System operations includes 50 hospitals and a comprehensive range of services provided across Alaska, California, Montana, New Mexico, Oregon, Texas, and Washington. The Health System also provides population health management through various affiliated licensed insurers and other risk-bearing entities.

The Health System has been recognized as exempt from federal income taxes, except on unrelated business income, under Section 501(a) of the Internal Revenue Code (IRC) as an organization described in Section 501(c)(3) and further described as a public charitable organization under Section 509(a)(3). PHS, SJHS, and substantially all of the various corporations within the Health System have been granted exemptions from federal income tax under Section 501(a) of the Internal Revenue Code as charitable organizations described in Section 501(c)(3). During 2017 and 2016, the Health System did not record any liability for unrecognized tax benefits.

The accompanying combined balance sheets and related combined statements of operations, changes in net assets, and cash flows reflect the Health System financial position and results of operations as of and for the year ended December 31, 2017. The Health System results of operations for the year ended December 31, 2016 include twelve months of results of operations for PHS and six months of results of operations for SJHS subsequent to acquisition.

(b) Basis of Presentation

The accompanying combined financial statements of the Health System were prepared in accordance with U.S. generally accepted accounting principles and include the assets, liabilities, revenues, and expenses of all wholly owned affiliates, majority-owned affiliates over which the Health System exercises control, and, when applicable, entities in which the Health System has a controlling financial interest.

Intercompany balances and transactions have been eliminated in combination.

(c) Performance Indicator

The performance indicator is the excess of revenues over expenses. Changes in unrestricted net assets that are excluded from the performance indicator include net assets released from restriction for the purchase of property plant and equipment, certain changes in funded status of pension and other

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

postretirement benefit plans, restricted contributions from affiliations, net changes in noncontrolling interests in combined joint ventures, and certain other activities.

(d) Operating and Nonoperating Activities

The Health System's primary mission is to meet the healthcare needs in its market areas through a broad range of general and specialized healthcare services, including inpatient acute care, outpatient services, physician services, long-term care, population health management, and other healthcare and health insurance services. Activities directly associated with the furtherance of this mission are considered to be operating activities. Other activities that result in gains or losses peripheral to the Health System's primary mission are considered to be nonoperating. Nonoperating activities include investment earnings, gains or losses from debt extinguishment, certain pension related costs, gains or losses on interest rate swaps, contributions from affiliations, and certain other activities.

(e) Use of Estimates and Assumptions

The preparation of the combined financial statements in conformity with U.S. generally accepted accounting principles requires the use of estimates and assumptions that affect the reported amounts of assets and liabilities and the reported amounts of revenues and expenses during the reporting periods. Significant estimates and assumptions are used for, but not limited to: (1) allowance for contractual revenue adjustments; (2) allowance for doubtful accounts; (3) fair value of acquired assets and assumed liabilities in business combinations; (4) fair value of investments; (5) reserves for self-insured healthcare plans; and (6) reserves for professional, workers' compensation and general insurance liability risks.

The accounting estimates used in the preparation of the combined financial statements will change as new events occur, additional information is obtained or the operating environment changes. Assumptions and the related estimates are updated on an ongoing basis and external experts may be employed to assist in the evaluation, as considered necessary. Actual results could materially differ from those estimates.

(f) Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with an original or remaining maturity of three months or less when acquired.

(g) Supplies Inventory

Supplies inventory is stated at the lower of cost (first-in, first-out) or market.

(h) Property, Plant, and Equipment

Property, plant, and equipment are stated at cost. Improvements and replacements of plant and equipment are capitalized, maintenance and repairs are expensed. The provision for depreciation is determined by the straight-line method, which allocates the cost of tangible property equally over its estimated useful life or lease term. Impairment of property, plant, and equipment is assessed when there is evidence that events or changes in circumstances have made recovery of the net carrying value of assets unlikely.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

Interest capitalized on amounts expended during construction is a component of the cost of additions to be allocated to future periods through the provision for depreciation. Capitalization of interest ceases when the addition is substantially complete and ready for its intended use.

Property, plant, and equipment and the total accumulated depreciation are as follows as of December 31:

	Approximate useful life (years)	2017	2016
Land	—	\$ 1,465	1,451
Buildings and improvements	5–60	9,714	9,434
Equipment:			
Fixed	5–25	1,278	1,254
Major movable and minor	3–20	5,833	5,470
Construction in progress	—	1,030	870
		<u>19,320</u>	<u>18,479</u>
Less accumulated depreciation		<u>(8,365)</u>	<u>(7,457)</u>
Property, plant, and equipment, net		<u>\$ 10,955</u>	<u>11,022</u>

Construction in progress primarily represents renewal and replacement of various facilities in the Health System's operating divisions, as well as costs capitalized to software development.

(i) Other Assets

Other assets primarily consist of investments in nonconsolidated joint ventures, beneficial interest in noncontrolled foundations, notes receivable, goodwill, and other intangible assets.

Other assets are as follows as of December 31:

	2017	2016
Investment in nonconsolidated joint ventures	\$ 315	285
Intangible assets	248	260
Goodwill	190	158
Beneficial interest in noncontrolled foundations	160	146
Other	284	269
Total other assets	<u>\$ 1,197</u>	<u>1,118</u>

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

Goodwill is recorded as the excess of cost over fair value of the acquired net assets. Indefinite-lived intangible assets are recorded at fair value using various methods depending on the nature of the intangible asset. Both goodwill and indefinite-lived intangible assets are tested at least annually for impairment. Definite-lived intangible assets are amortized using the straight-line method over the estimated useful lives of the assets.

The Health System recorded goodwill impairment of \$14 and \$36 during the years ended December 31, 2017 and 2016, respectively attributable to medical group acquisitions made in previous years.

(j) Investments Including Assets Whose Use Is Limited

The Health System has classified all of its investments as trading securities. These investments are reported on the combined balance sheets at fair value on a trade-date basis.

Investment sales and purchases initiated prior to and settled subsequent to the combined balance sheet date result in amounts due from and to brokers. As of December 31, 2017, the Health System recorded a receivable of \$174 for investments sold but not settled and a payable of \$428 for investments purchased but not settled in other current assets and other current liabilities, respectively, in the accompanying combined balance sheets. As of December 31, 2016, the Health System recorded a receivable of \$136 for investments sold but not settled and a payable of \$375 for investments purchased but not settled in other current assets and other current liabilities, respectively, in the accompanying combined balance sheets.

Assets whose use is limited primarily include assets held by trustees under indenture agreements, self-insurance funds, funds held for the payment of health plan medical claims and other statutory reserve requirements, assets held by related foundations, and designated assets set aside by management of the Health System for future capital improvements and other purposes, over which management retains control.

Investment income from investments including assets whose use is limited are included in net nonoperating gains (losses) and are comprised of the following for the years ended December 31:

	2017	2016
Interest and dividend income	\$ 121	87
Net realized gains (losses) on sale of trading securities	166	(9)
Change in net unrealized gains on trading securities	595	325
Investment income, net	\$ 882	403

(k) Derivative Instruments

The Health System uses derivative financial instruments (interest rate swaps) to manage its interest rate exposure and overall cost of borrowing. As of December 31, 2017 and 2016, the Health System had interest rate swap contracts with a total current notional amount totaling \$467 and \$480, respectively, with varying expiration dates.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

Derivative financial instruments are recorded at fair value taking into consideration the Health System's and the counterparties' nonperformance risk. As of December 31, 2017 and 2016, the fair value of outstanding interest rate swaps was in a net liability position of \$101 and \$104, respectively, and is included in other liabilities in the accompanying combined balance sheets. As of December 31, 2017 and 2016, collateral posted in connection with the outstanding swap agreements was \$6 and \$5, respectively, and is included in other assets in the accompanying combined balance sheets.

The interest rate swap agreements do not meet the criteria for hedge accounting and all changes in the valuation are recognized as a component of net nonoperating gains (losses) in the accompanying combined statements of operations. Settlements related to these agreements are recognized as a component of interest, depreciation, and amortization expense in the accompanying combined statements of operations. For the years ended December 31, 2017 and 2016, the change in valuation was a gain of \$4 and \$52, respectively, and settlements recognized as a component of interest expense were \$12 and \$7, respectively.

The Health System also allows certain investment managers to use derivative financial instruments (futures and forward currency contracts) to manage interest rate risk related to the Health System's fixed-income holdings. The investment managers have executed master netting arrangements with the counterparties of the futures and forward currency purchase and sale contracts whereby the financial instruments held by the same counterparty are legally offset as the instruments are settled. The following table presents gross investment derivative assets and liabilities reported on a net basis at fair value included in assets whose use is limited in the combined balance sheets as of December 31:

	2017	2016
Derivative assets:		
Futures contracts	\$ 275	394
Foreign currency forwards and other contracts	86	80
Total derivative assets	\$ 361	474
Derivative liabilities:		
Futures contracts	\$ (275)	(394)
Foreign currency forwards and other contracts	(84)	(76)
Total derivative liabilities	\$ (359)	(470)

(I) Self-Insurance Liabilities

The Health System has established self-insurance programs for professional and general liability and workers' compensation insurance coverage. These programs provide insurance coverage for healthcare institutions associated with the Health System. The Health System also operates insurance captives, Providence Assurance, Inc. and American Unity Group, Ltd., to self-insure or reinsure certain layers of professional and general liability risk.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

The Health System accrues estimated self-insured professional and general liability and workers' compensation insurance claims based on management's estimate of the ultimate costs for both reported claims and actuarially determined estimates of claims incurred but not reported. Insurance coverage in excess of the per occurrence self-insured retention has been secured with insurers or reinsurers for specified amounts for professional, general, and workers' compensation liabilities. Decisions relating to the limit and scope of the self-insured layer and the amounts of excess insurance purchased are reviewed each year, subject to management's analysis of actuarial loss projections and the price and availability of acceptable commercial insurance.

At December 31, 2017 and 2016, the estimated liability for future costs of professional and general liability claims was \$357 and \$302, respectively. At December 31, 2017 and 2016, the estimated workers' compensation obligation was \$309 and \$306, respectively, both are recorded in other current liabilities and other liabilities in the accompanying combined balance sheets.

(m) Net Assets

Unrestricted net assets are those that are not subject to donor-imposed stipulations. Amounts related to the Health System's noncontrolling interests in certain joint ventures are included in unrestricted net assets. Temporarily restricted net assets are those whose use by the Health System has been limited by donors to a specific time period and/or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Health System in perpetuity. Unless specifically stated by donors, gains and losses on permanently restricted net assets are recorded as temporarily restricted.

Temporarily restricted net assets are available for the following purposes as of December 31:

	<u>2017</u>	<u>2016</u>
Program support	\$ 657	570
Capital acquisition	168	144
Low-income housing and other	<u>133</u>	<u>102</u>
Total temporarily restricted net assets	<u>\$ 958</u>	<u>816</u>

(n) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Health System are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the promise to give is no longer conditional. The gifts are reported as either temporarily or permanently restricted contributions if they are received with donor stipulations that limit the use of the donated assets. When the terms of a donor restriction are met, temporarily restricted net assets are reclassified as unrestricted net assets and reported as other operating revenues in the combined statements of operations or as net assets released from restriction for donations of capital in the combined statements of changes in net assets.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

(o) Net Patient Service Revenues

The Health System has agreements with governmental and other third-party payors that provide for payments to the Health System at amounts different from established charges. Payment arrangements for major third-party payors may be based on prospectively determined rates, reimbursed cost, discounted charges, per diem payments, or other methods.

Net patient service revenues are reported at the estimated net realizable amounts due from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with governmental payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as appropriate. Adjustments from finalization of prior years' cost reports and other third-party settlement estimates resulted in an increase in net patient service revenues of \$27 for the year ended December 31, 2017 and a decrease in net patient service revenues of \$1 for the year ended December 31, 2016, respectively.

The composition of payors as a percentage of net patient service revenues are as follows for the years ended December 31:

	<u>2017</u>	<u>2016</u>
Commercial	50 %	49 %
Medicare	33	32
Medicaid	14	16
Self-pay and other	3	3
	<u>100 %</u>	<u>100 %</u>

Various states in which the Health System operates have instituted a provider tax on certain patient service revenues at qualifying hospitals to increase funding from other sources and obtain additional Federal funds to support increased payments to providers for Medicaid services. The taxes are included in purchased services, professional fees, and other expenses in the accompanying combined statements of operations and were \$434 and \$495 for the years ended December 31, 2017 and 2016, respectively. These programs resulted in enhanced payments from these states in the way of lump-sum payments and per claim increases. These enhanced payments are included in net patient service revenues in the accompanying combined statements of operations and were \$471 and \$616 for the years ended December 31, 2017 and 2016, respectively.

(p) Allowance for Bad Debts

The Health System provides for an allowance against patient accounts receivable for amounts that could become uncollectible. The Health System estimates this allowance based on the aging of accounts receivable, historical collection experience by payor, and other relevant factors. There are various factors that can impact the collection trends, such as changes in the economy, which in turn have an impact on unemployment rates and the number of uninsured and underinsured patients, the increased burden of copayments to be made by patients with insurance coverage and business

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

practices related to collection efforts. These factors continuously change and can have an impact on collection trends and the estimation process used by the Health System. The Health System records a provision for bad debts in the period of services on the basis of past experience, which has historically indicated that many patients are unresponsive or are otherwise unwilling to pay the portion of their bill for which they are financially responsible.

The estimates made and changes affecting those estimates are summarized as follows for the years ended December 31:

	<u>2017</u>	<u>2016</u>
Changes in allowance for bad debts:		
Allowance for doubtful accounts at beginning of year	\$ 271	344
Write-off of uncollectible accounts, net of recoveries	(313)	(276)
Provision for bad debts	<u>269</u>	<u>203</u>
Allowance for bad debts at end of year	<u>\$ 227</u>	<u>271</u>

(q) Charity Care and Community Benefit

The Health System provides community benefit activities that address significant health priorities within its geographic service areas. These activities include Medicaid and Medicare shortfalls, community health services, education and research, and free and low-cost care (charity care).

Charity care is reported at cost and is determined by multiplying the charges incurred at established rates for services rendered by the Health System's cost-to-charge ratio. The cost of charity care provided by the Health System for the years ended December 31, 2017 and 2016 was \$259 and \$174, respectively.

(r) Premium and Capitation Revenues

Premium and capitation revenues are received on a prepaid basis and are recognized as revenue during the month for which the enrolled member is entitled to healthcare services. Premium and capitation revenues received for future months are recorded as unearned premiums.

(s) Functional Expenses

The Health System provides healthcare services to residents within its geographic service areas. Expenses related to providing these services are as follows for the years ended December 31:

	<u>2017</u>	<u>2016</u>
Healthcare expenses	\$ 16,983	14,300
Purchased healthcare expenses	2,539	1,917
General and administrative expenses	<u>3,638</u>	<u>2,911</u>
Total operating expenses	<u>\$ 23,160</u>	<u>19,128</u>

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

(t) Subsequent Events

In February 2018, the Health System issued \$350 of Series 2018A taxable bonds and \$142 of Series 2018B Washington Health Care Facilities Authority revenue bonds.

The Health System has performed an evaluation of subsequent events through March 7, 2018, the date the accompanying combined financial statements were issued.

(u) New Accounting Pronouncements

In March 2017, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2017-07, *Compensation – Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. The Health System adopted the ASU for the period beginning January 1, 2017, and \$38 in net periodic benefit costs were recorded in net nonoperating gains (losses) on the statements of operations for the period ended December 31, 2017.

In January 2016, the FASB issued ASU 2016-01, *Financial Instruments – Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities*, which updates certain aspects of recognition, measurement, presentation and disclosure of financial instruments. The Health System has evaluated the impact and will be implementing ASU 2016-01 for the fiscal year beginning January 1, 2018.

In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)*, to clarify the principles for recognizing revenue and to improve financial reporting by creating common revenue recognition guidance for U.S. generally accepted accounting principles and International Financial Reporting Standards. The amendments in the ASU can be applied either retrospectively to each prior reporting period presented or retrospectively with the cumulative effect of initially applying the update recognized at the date of the initial application along with additional disclosures. The Health System evaluated the impact of ASU 2014-09 and is implementing this ASU beginning January 1, 2018. Management will include new disclosures in 2018, in accordance with Topic 606. The adoption of Topic 606 will not have a significant impact on the Health System's results of operations.

In February 2016, the FASB issued ASU 2016-02, *Leases*, which requires lessees to recognize a lease liability and a right of use asset for all lease obligations with exception to short-term leases. The lease liability will represent the lessee's obligation to make lease payments arising from the lease measured on a discounted basis and the right of use asset will represent the lessee's right to use or control the use of a specified asset for a lease term. The lease guidance also simplifies accounting for sale-leaseback transactions. Because of the number of leases the Health System utilizes to support its operations, the adoption of ASU 2016-02 is expected to have a significant impact on the Health System's combined financial position and results of operations. The Health System is currently evaluating the extent of the anticipated impact of the adoption of ASU 2016-02, which is effective for the fiscal year beginning on January 1, 2019 with modified retrospective application to the earliest presented period.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

In August 2016, the FASB issued ASU 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities*, with the intent of reducing diversity in reporting practice, reduce complexity, and enhance understandability of not-for-profit (NFP) financial statements. This ASU contains the following key aspects; (A) Reduces the number of net asset classes presented from three to two: with donor restrictions and without donor restrictions; (B) Requires all NFPs to present expenses by their functional and their natural classifications in one location in the financial statements; (C) Requires NFPs to provide quantitative and qualitative information about management of liquid resources and availability of financial assets to meet cash needs within one year of the balance sheet date; and (D) Retains the options to present operating cash flows in the statement of cash flows using either the direct or indirect method. The Health System has evaluated the impact of ASU 2016-14 and will be implementing this ASU for the fiscal year beginning January 1, 2018. The impact of adoption will result in enhanced disclosures about the classification of expenses and management of liquid resources.

(v) Reclassifications

Certain reclassifications, which have no impact on net assets or changes in net assets, have been made to prior year amounts to conform to the current year presentation.

(2) Affiliated Activities and Divestitures

Effective February 23, 2017 the Health System and Catholic Health Initiatives entered into an agreement with Laboratory Corporation of America to sell all of its ownership interest in Pathology Associates Medical Laboratories (PAML) and its affiliated joint ventures. PAML was a PHS consolidated joint venture. A gain in the amount of \$133 was recorded in other operating revenues on the combined statements of operations during the year ended December 31, 2017.

On July 1, 2016, PHS and SJHS entered into a business combination agreement, the purpose of which was to better serve both organizations' communities, maintain strong traditions of Catholic healthcare, and provide greater affordability and access to healthcare services. As part of the business combination, PHS and SJHS aligned under a single parent corporation, Providence St. Joseph Health, with a consolidated board of directors and cosponsorship from the public juridic persons Providence Ministries and St. Joseph Health Ministry.

SJHS provides a full range of care facilities including 16 acute care hospitals, home health agencies, hospice care, outpatient services, skilled nursing facilities, community clinics, and physician groups spanning California, west Texas, and eastern New Mexico. The results of operations of these entities have been included in the combined statements of operations of the Health System since July 1, 2016, the effective date of the business combination.

The transition was accounted for as an acquisition under Accounting Standards Codification (ASC) 958-805, *Not-for-Profit Entities – Business Combinations*. The affiliation did not involve consideration and resulted in an excess of assets acquired over liabilities assumed, reported as a contribution of net assets from SJHS to the Health System of approximately \$5,644. The unrestricted portion of the contribution of \$5,163 is included in net nonoperating gains in the accompanying combined statement of operations for the year ended December 31, 2016. The remaining \$481 of the contribution was restricted and is recorded in restricted net assets in the combined statement of changes in net assets for the year ended December 31, 2016.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

The following table summarizes the fair value estimate of the SJHS assets acquired and liabilities assumed as of July 1, 2016:

Cash and cash equivalents	\$	359
Accounts receivable, net		607
Supplies inventory		66
Other current assets		290
Assets whose use is limited		3,372
Property, plant, and equipment, net		4,388
Other assets		555
Accounts payable		(146)
Accrued compensation		(344)
Other current liabilities		(569)
Long-term debt		(2,486)
Other liabilities		(448)
Total contribution of net assets	\$	<u>5,644</u>

The following are the financial results of SJHS included in the Health System's 2016 combined statement of operations during the six-month period from the date of the affiliation through December 31, 2016:

Total operating revenues	\$	3,520
Excess of revenue over expenses from operations		46
Excess of revenues over expenses		130

The following unaudited pro forma combined financial information presents the Health System's results as if the affiliation had been reported as of the beginning of the Health System's fiscal year of January 1, 2016:

	2016	
	Actual	Pro forma (Unaudited)
Total operating revenues	\$ 18,879	22,157 (1)
Deficit of revenues over expenses from operations	(249)	(265) (1)(2)
Excess of revenues over expenses	5,231	57 (1)

(1) Includes the historical results of SJHS for the six-month period ended June 30, 2016 prior to the affiliation, including the impact of purchase accounting adjustments.

(2) Includes additional depreciation related to the fair value adjustments and useful life adjustments recorded related to the affiliation.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

Effective April 1, 2016, the Health System entered into a business combination agreement with the Institute for Systems Biology (ISB). The transaction was accounted for as an acquisition under ASC 958-805. The affiliation resulted in an excess of assets acquired over liabilities assumed, reported as a contribution from ISB to the Health System of approximately \$19. The unrestricted portion of the contribution of \$4 is included in net nonoperating gains in the accompanying combined statement of operations for the year ended December 31, 2016. The remaining \$15 of the contribution was restricted and is recorded in restricted net assets in the combined statement of changes in net assets for year ended December 31, 2016.

(3) Fair Value Measurements

ASC Topic 820 (Topic 820), *Fair Value Measurements*, requires a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs include quoted prices (unadjusted) in active markets for identical assets or liabilities that the Health System has the ability to access at the measurement date.
- Level 2 inputs include inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly.
- Level 3 inputs are unobservable inputs for the asset or liability.

The level in the fair value hierarchy within which a fair value measurement in its entirety falls is based on the lowest-level input that is significant to the fair value measurement in its entirety.

(a) Assets Whose Use Is Limited

The fair value of assets whose use is limited, other than those investments measured using NAV as a practical expedient for fair value, is estimated using quoted market prices or other observable inputs when quoted market prices are unavailable.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

The composition of assets whose use is limited is set forth in the following tables:

	December 31,	Fair value measurements at reporting date using		
	2017	Level 1	Level 2	Level 3
Management-designated cash and investments:				
Cash and cash equivalents	\$ 547	547	—	—
Equity securities:				
Domestic	1,058	1,058	—	—
Foreign	372	372	—	—
Mutual funds	1,313	1,313	—	—
Domestic debt securities:				
State and federal government	1,441	961	480	—
Corporate	717	—	717	—
Other	460	—	460	—
Foreign debt securities	155	—	155	—
Commingled funds	545	545	—	—
Other	20	—	20	—
Investments measured using NAV	3,312			
Total management-designated cash and investments	<u>9,940</u>			
Gift annuities, trusts, and other	181	41	35	105
Funds held by trustee:				
Cash and cash equivalents	105	105	—	—
Domestic debt securities	216	113	103	—
Foreign debt securities	24	—	24 ¹	—
Total funds held by trustee	<u>345</u>			
Total assets whose use is limited	<u>\$ 10,466</u>			

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

	December 31, 2016	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
Management-designated cash and investments:				
Cash and cash equivalents	\$ 572	572	—	—
Equity securities:				
Domestic	1,000	1,000	—	—
Foreign	280	280	—	—
Mutual funds	828	828	—	—
Domestic debt securities:				
State and federal government	1,518	1,011	507	—
Corporate	766	—	766	—
Other	503	—	503	—
Foreign debt securities	172	—	172	—
Commingled funds	575	575	—	—
Other	32	20	12	—
Investments measured using NAV	<u>2,752</u>			
Total management-designated cash and investments	<u>8,998</u>			
Gift annuities, trusts, and other	131	32	11	88
Funds held by trustee:				
Cash and cash equivalents	147	147	—	—
Domestic debt securities	198	68	130	—
Foreign debt securities	<u>23</u>	—	23	—
Total funds held by trustee	<u>368</u>			
Total assets whose use is limited	<u>\$ 9,497</u>			

The Health System participates in various funds that are not actively marketed on an open exchange. These investments consist of shares or units in investment funds as opposed to direct interests in the funds' underlying holdings, which may be marketable. Due to the nature of these funds the NAV per share, or its equivalent, reported by each fund manager is used as a practical expedient to estimate the fair value of the Health System's interest therein. Management believes that the carrying amounts of these financial instruments, provided by the fund managers, are reasonable estimates of fair value.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

The following table presents information, including unfunded commitments as of December 31, 2017, for investments where the NAV was used to estimate the value of the investments as of December 31:

	<u>Fair value</u>		<u>Unfunded commitments</u>	<u>Redemption frequency</u>	<u>Redemption notice period</u>
	<u>2017</u>	<u>2016</u>			
Hedge funds:					
Long/short equity	\$ 579	501	—	Monthly, quarterly, semi-annually, or annually	30–120 days
Credit	300	166	—	Quarterly or annually	45–150 days
Relative value	206	194	—	Quarterly	60–90 days
Global macros	278	226	—	Monthly or quarterly	2–90 days
Fund of hedge funds	82	80	—	Quarterly	90 days
Private equity	258	214	350	Not applicable	Not applicable
Private real estate	75	33	159	Not applicable	Not applicable
Risk parity	110	173	—	Monthly or annually	5–60 days
Real assets	315	327	60	Monthly or quarterly	10–60 days
Commingled	1,109	838	—	Monthly, quarterly, or semi-annually	6–90 days
	<u>3,312</u>	<u>2,752</u>	<u>569</u>		
Total	\$ <u>3,312</u>	<u>2,752</u>	<u>569</u>		

The following is a summary of the nature of these investments and their associated risks:

Hedge funds are portfolios of investments that use advanced investment strategies, such as long/short equity, credit, relative value, global macro, and fund of hedge funds positions in both domestic and international markets, with the goal of diversifying portfolio risk and generating return. The Health System's investments in hedge funds include certain funds with provisions that limit the Health System's ability to access assets invested. These provisions include lockup terms that range up to three years from the subscription date or are continuous and determined as a percent of total assets invested. The Health System is in various stages of the lockup periods dependent on hedge fund and period of initial investments.

Private equity and private real estate funds make opportunistic investments that are primarily private in nature. These investments cannot be redeemed by the Health System; rather the Health System has committed an amount to invest in the private funds over the respective commitment periods. After the commitment period has ended, the nature of the investments in this category is that the distributions are received through the liquidation of the underlying assets.

Risk parity is an approach to investment portfolio management which focuses on allocation of risk, usually defined as volatility, rather than allocation of capital. The risk parity approach asserts that when asset allocations are adjusted to the same risk level, the risk parity portfolio can achieve a higher Sharpe ratio and can be more resistant to market downturns than the traditional portfolio. The key to risk parity is to diversify across asset classes that behave differently across economic environments.

Real asset strategies invest in securities backed by tangible real assets, with the objective of achieving attractive diversified total returns over the long term, while maximizing the potential for real returns in

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

periods of rising inflation. Real asset investments should provide a return in excess of inflation, and their performance should be sensitive to changes in inflation or expectations for future levels of inflation. The real asset category is made up of many different underlying sectors inclusive of agriculture, commodities, gold, infrastructure, private energy, MLPs (Master Limited Partnerships), real estate, REITs (Real Estate Investment Trusts), timberland, and TIPS (Treasury Inflation Protected Securities). Each of these sectors tends to have a high degree of sensitivity to inflation and be less correlated with traditional equities and fixed income.

Commingled describes a type of fund structure. Commingled funds consist of assets from several accounts that are blended together. Investors in commingled fund investments benefit from economies of scale, which allow for lower trading costs per dollar of investment.

(b) Derivative Instruments

The fair value of the interest rate swaps is based on independent valuations obtained and are determined by calculating the value of the discounted cash flows of the differences between the fixed interest rate of the interest rate swaps and the counterparty's forward London Interbank Offered Rate curve, which is the input used in the valuation, taking also into account any nonperformance risk. Collateral posted for the interest rate swaps consist of cash and U.S. government securities, which are both categorized as Level 1 financial instruments.

The following tables present the fair value of swaps and related collateral:

	<u>December 31, 2017</u>	<u>Fair value measurements at reporting date using</u>		
		<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>
Cash collateral held by swap counterparty	\$ 6	6	—	—
Liabilities under interest rate swaps	101	—	101	—
	<u>December 31, 2016</u>	<u>Fair value measurements at reporting date using</u>		
		<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>
Cash collateral held by swap counterparty	\$ 5	5	—	—
Liabilities under interest rate swaps	104	—	104	—

(c) Debt

The fair value of long-term debt is based on Level 2 inputs, such as the discounted value of the future cash flows using current rates for debt with the same remaining maturities, considering the existing call premium and protection. The carrying value and fair value of long-term debt was \$6,620 and \$6,963, respectively, as of December 31, 2017, and \$6,749 and \$6,980, respectively, as of December 31, 2016.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

(d) Assets Measured Using Significant Unobservable Inputs

The following table presents the Health System's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in Topic 820:

Balance at December 31, 2015	\$	62
Level 3 assets acquired through affiliation		8
Total realized and unrealized gains, net		1
Total purchases		16
Total sales		(3)
Transfers into Level 3		4
		88
Balance at December 31, 2016		88
Total realized and unrealized losses, net		(2)
Total purchases		21
Total sales		(2)
		105
Balance at December 31, 2017	\$	105

There were no significant transfers between assets classified as Level 1 and Level 2 during the years ended December 31, 2017 and 2016.

Level 3 assets include charitable remainder trusts, real property, and equity investments in healthcare technology start-ups through the Health System's innovation venture capital fund. Fair values of real property were estimated using a market approach. Fair values of charitable remainder trusts were estimated using an income approach. Fair value of equity investments in healthcare technology start-ups were estimated using a combination of income and market approach.

(4) Debt

(a) Short-Term and Long-Term Debt

The Health System has borrowed master trust debt issued through the following:

- California Health Facilities Financing Authority (CHFFA)
- Alaska Industrial Development and Export Authority (AIDEA)
- Washington Health Care Facilities Authority (WHCFA)
- Montana Facility Finance Authority (MFFA)
- Lubbock Health Facilities Development Corp (LHFDC)
- Oregon Facilities Authority (OFA)

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

Short-term and long-term unpaid principal at December 31 consists of the following:

	Maturing through	Coupon rates	Unpaid principal	
			2017	2016
Master trust debt:				
Fixed rate:				
Series 1997, Direct Obligation Notes	2017	7.70%	\$ —	1
Series 2005, Direct Obligation Notes	2030	4.31–5.39%	40	42
Series 2006C, WHCFA Revenue Bonds	2033	5.25%	69	69
Series 2006D, WHCFA Revenue Bonds	2033	5.25%	69	69
Series 2006E, WHCFA Revenue Bonds	2033	5.25%	26	26
Series 2008B, LHFDC Revenue Bonds	2023	4.00–5.00%	33	46
Series 2008C, CHFFA Revenue Bonds	2038	3.00–6.50%	6	12
Series 2009A, Direct Obligation Notes	2019	5.05–6.25%	100	100
Series 2009A, CHFFA Revenue Bonds	2039	5.50–5.75%	185	185
Series 2009B, CHFFA Revenue Bonds	2039	5.50%	150	150
Series 2009B, CHFFA Revenue Bonds	2021	3.00–5.25%	37	42
Series 2009C, CHFFA Revenue Bonds	2034	5.00%	91	91
Series 2009D, CHFFA Revenue Bonds	2034	1.70%	40	40
Series 2010A, WHCFA Revenue Bonds	2039	4.88–5.25%	174	174
Series 2011A, AIDEA Revenue Bonds	2041	5.00–5.50%	123	123
Series 2011B, WHCFA Revenue Bonds	2021	2.00–5.00%	42	51
Series 2011C, OFA Revenue Bonds	2026	3.50–5.00%	15	17
Series 2012A, WHCFA Revenue Bonds	2042	2.00–5.00%	480	489
Series 2012B, WHCFA Revenue Bonds	2042	4.00–5.00%	100	100
Series 2013A, OFA Revenue Bonds	2024	2.00–5.00%	54	61
Series 2013A, CHFFA Revenue Bonds	2037	4.00–5.00%	325	325
Series 2013B, CHFFA Revenue Bonds	2043	4.15–4.26%	—	110
Series 2013C, CHFFA Revenue Bonds	2043	4.15–4.26%	110	110
Series 2013D, Direct Obligation Notes	2023	4.38%	252	252
Series 2013D, CHFFA Revenue Bonds	2043	4.15–4.26%	110	110
Series 2014A, CHFFA Revenue Bonds	2038	2.00–5.00%	270	273
Series 2014B, CHFFA Revenue Bonds	2044	4.25–5.00%	119	119
Series 2014C, WHCFA Revenue Bonds	2044	4.00–5.00%	92	92
Series 2014D, WHCFA Revenue Bonds	2041	5.00%	179	179
Series 2015A, WHCFA Revenue Bonds	2045	4.00%	78	78
Series 2015C, OFA Revenue Bonds	2045	4.00–5.00%	71	71
Series 2016A, CHFFA Revenue Bonds	2047	2.50–5.00%	448	448
Series 2016B, CHFFA Revenue Bonds	2036	1.25–4.00%	286	286
Series 2016H, Direct Obligation Bonds	2036	2.75%	300	300
Series 2016I, Direct Obligation Bonds	2047	3.74%	400	400
Total fixed rate			4,874	5,041

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

	Maturing through	Effective interest rate (1)		Unpaid principal	
		2017	2016	2017	2016
Variable rate:					
Series 2012C, WHCFA Revenue Bonds	2042	0.86 %	0.43 %	80	80
Series 2012D, WHCFA Revenue Bonds	2042	0.86	0.43	80	80
Series 2012E, Direct Obligation Notes	2042	1.08	0.57	229	231
Series 2013C, OFA Revenue Bonds	2022	1.79	1.41	57	117
Series 2013E, Direct Obligation Notes	2017	6.28	4.79	—	100
Series 2016C, LHFDC Revenue Bonds	2030	0.86	0.24	37	39
Series 2016D, WHCFA Revenue Bonds	2036	1.34	1.04	106	106
Series 2016E, WHCFA Revenue Bonds	2036	1.26	0.96	106	106
Series 2016F, MFFA Revenue Bonds	2026	1.23	0.93	46	50
Series 2016G, Direct Obligation Notes	2047	1.08	0.76	100	100
Total variable rate				841	1,009
Wells Fargo Credit Facility	2019	1.73	—	110	—
Wells Fargo Credit Facility	2021	1.63	1.22	369	252
Unpaid principal, master trust debt				6,194	6,302
Premiums, discounts, and unamortized financing costs, net				148	167
Master trust debt, including premiums and discounts, net				6,342	6,469
Other long-term debt				278	280
Total debt				\$ 6,620	6,749

(1) Variable rate debt and credit facilities carry floating interest rates attached to indexes, which are subject to change based on market conditions.

In November 2017, the Health System received a Well Fargo Bridge Loan for \$110 and repaid the CHFFA Series 2013B revenue bonds.

In September and November 2016, the Health System issued \$1,835 Series 2016A through 2016I revenue bonds and direct obligation notes. The intended uses of funds included refinancing legacy SJHS and PHS master trust debt and repayment of outstanding lines of credit and commercial paper. Certain issues within the 2016 series debt included remarketing provisions for which the Health System purchased supporting credit facilities that allow the Health System to treat the obligations as noncurrent though remarketing may occur within less than one year.

In connection with the Series 2016A-I issuance, the Health System recorded losses due to extinguishment of debt of \$60 in the year ended December 31, 2016, which was recorded in net nonoperating gains (losses) in the accompanying combined statement of operations.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

The following table reflects classification of long-term debt obligations in the accompanying combined balance sheets as of December 31:

	<u>2017</u>	<u>2016</u>
Current portion of long-term debt	\$ 78	200
Short-term master trust debt	57	153
Long-term debt, classified as a long-term liability	<u>6,485</u>	<u>6,396</u>
Total debt	<u>\$ 6,620</u>	<u>6,749</u>

Short-term master trust debt represents debt issues with remarketing provisions unsupported by credit facilities with mandatory redemption within one year of the December 31, 2017 and 2016.

(b) Other Long-Term Debt

Other long-term debt primarily includes capital leases, notes payable, and bonds that are not under the master trust indenture. Other long-term debt at December 31 consists of the following:

	<u>2017</u>	<u>2016</u>
Capital leases	\$ 152	159
Notes payable	105	110
Bonds not under master trust indenture and other	<u>21</u>	<u>11</u>
Total other long-term debt	<u>\$ 278</u>	<u>280</u>

(c) Debt Service

Scheduled principal payments of long-term debt, considering all obligations under the master trust indenture as due according to their long-term amortization schedule, for the next five years and thereafter are as follows:

	<u>Master trust</u>	<u>Other</u>	<u>Total</u>
2018	\$ 69	9	78
2019	283	11	294
2020	93	11	104
2021	472	10	482
2022	107	10	117
Thereafter	<u>5,170</u>	<u>227</u>	<u>5,397</u>
Scheduled principal payments of long-term debt	<u>\$ 6,194</u>	<u>278</u>	<u>6,472</u>

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

(5) Retirement Plans

(a) Defined Benefit Plans

The Health System sponsors various frozen defined benefit retirement plans. The measurement dates for the defined benefit plans are December 31. A rollforward of the change in projected benefit obligation and change in the fair value of plan assets for the defined benefit plans is as follows:

	2017	2016
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	\$ 2,680	2,600
Service cost	23	22
Interest cost	114	94
Actuarial loss	110	140
Benefits paid and other	(186)	(176)
	2,741	2,680
Change in fair value of plan assets:		
Fair value of plan assets at beginning of year	1,559	1,535
Actual return on plan assets	218	119
Employer contributions	95	81
Benefits paid and other	(186)	(176)
	1,686	1,559
Funded status	(1,055)	(1,121)
Unrecognized net actuarial loss	495	552
Unrecognized prior service cost	3	4
	\$ (557)	(565)
Amounts recognized in the combined balance sheets consist of:		
Current liabilities	\$ (1)	(1)
Noncurrent liabilities	(1,054)	(1,120)
Unrestricted net assets	498	556
	\$ (557)	(565)
Weighted average assumptions:		
Discount rate	4.00 %	4.40 %
Rate of increase in compensation levels	3.50	3.50
Long-term rate of return on assets	6.50	6.90

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

Net periodic pension cost for the defined benefit plans includes the following components:

	2017	2016
Components of net periodic pension cost:		
Service cost	\$ 23	22
Interest cost	114	94
Expected return on plan assets	(102)	(107)
Amortization of prior service cost	1	1
Recognized net actuarial loss	25	19
Net periodic pension cost	\$ 61	29
Special recognition – settlement expense	\$ 25	28

Certain plans sponsored by the Health System allow participants to receive their benefit through a lump-sum distribution upon election. When lump-sum distributions exceed the combined total of service cost and interest cost during a reporting period settlement expense is recognized. Settlement expense represents the proportional recognition of unrecognized actuarial loss and prior service cost. Settlement expense for the years ended December 31, 2017 and 2016 is included in net nonoperating gains (losses) in the accompanying combined statements of operations.

The accumulated benefit obligation was \$2,672 and \$2,628 at December 31, 2017 and 2016, respectively.

The following pension benefit payments reflect expected future service. Payments expected to be paid over the next 10 years are as follows:

2018	\$ 178
2019	185
2020	191
2021	195
2022–2027	1,077
	\$ 1,826

The Health System expects to contribute approximately \$96 to the defined benefit plans in 2018.

The expected long-term rate of return on plan assets is the expected average rate of return on the funds invested currently and on funds to be invested in the future in order to provide for the benefits included in the projected benefit obligation. The Health System used 6.5% and 6.9% in calculating the 2017 and 2016 expense amounts, respectively. This assumption is based on capital market assumptions and the plan's target asset allocation.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

The Health System continues to monitor the expected long-term rate of return. If changes in those parameters cause 6.5% to be outside of a reasonable range of expected returns, or if actual plan returns over an extended period of time, suggest that general market assumptions are not representative of expected plan results, the Health System may revise this estimate prospectively.

The target asset allocation and expected long-term rate of return on assets (ELTRA) as of December 31, 2017 and 2016, respectively, were as follows:

	<u>2017 Target</u>	<u>2017 ELTRA</u>	<u>2016 Target</u>	<u>2016 ELTRA</u>
Cash and cash equivalents	2 %	2%–3%	1 %	1%–3%
Equity securities	45	7%–8%	42	5%–9%
Debt securities	33	3%–4%	35	2%–5%
Other securities	20	5%–8%	22	5%–9%
Total	<u>100 %</u>	<u>6.5 %</u>	<u>100 %</u>	<u>6.9 %</u>

The following table presents the Health System's defined benefit plan assets measured at fair value:

	<u>December 31, 2017</u>	<u>Fair value measurements at reporting date using</u>		
		<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>
Assets:				
Cash and cash equivalents \$	68	68	—	—
Equity securities:				
Domestic	177	177	—	—
Foreign	48	48	—	—
Mutual funds	127	127	—	—
Domestic debt securities:				
State and government	272	210	62	—
Corporate	129	—	129	—
Other	13	—	13	—
Foreign debt securities	30	—	30	—
Commingled funds	170	170	—	—
Investments measured using NAV	720			
Transactions pending settlement, net	(68)			
Total	<u>\$ 1,686</u>			

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

The following table presents the Health System's defined benefit plan assets measured at fair value:

	December 31, 2016	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
Assets:				
Cash and cash equivalents \$	58	58	—	—
Equity securities:				
Domestic	192	192	—	—
Foreign	37	37	—	—
Mutual funds	104	104	—	—
Domestic debt securities:				
State and government	251	173	78	—
Corporate	115	—	115	—
Other	15	—	15	—
Foreign debt securities	30	—	30	—
Commingled funds	157	157	—	—
Investments measured using NAV	663			
Transactions pending settlement, net	(63)			
Total	\$ 1,559			

The Health System's defined benefit plans participate in various funds that are not actively marketed on an open exchange. These investments consist of shares or units in investment funds as opposed to direct interests in the funds' underlying holdings, which may be marketable. Due to the nature of these funds the NAV per share, or its equivalent, reported by each fund manager is used as a practical expedient to estimate the fair value of the Health System's interest therein. Management believes that the carrying amounts of these financial instruments provided by the fund managers are reasonable estimates of fair value.

The following table presents information for investments where either the NAV per share or its equivalent was used to value the investments as of December 31:

	Fair value		Redemption frequency	Redemption notice period
	2017	2016		
Hedge funds:				
Long/short equity	\$ 52	74	Monthly or quarterly	30–65 days
Credit and other	56	52	Monthly or quarterly	90 days
Real assets	92	116	Monthly	30 days
Risk parity	130	111	Monthly	5–15 days
Commingled	390	310	Monthly	6–30 days
Total	\$ 720	663		

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

The Health System's defined benefit plans also allow certain investment managers to use derivative financial instruments (futures and forward currency contracts) to manage interest rate risk related to the plans' fixed-income holdings. The investment managers have executed master netting arrangements with the counterparties of the futures and forward currency purchase and sale contracts whereby the financial instruments held by the same counterparty are legally offset as the instruments are settled. The following table presents gross investment derivative assets and liabilities reported on a net basis at fair value included in the plans' assets as of December 31:

	2017	2016
Derivative assets:		
Futures contracts	\$ 926	16
Foreign currency forwards and other contracts	5	7
Total derivative assets	\$ 931	23
Derivative liabilities:		
Futures contracts	\$ (926)	(16)
Foreign currency forwards and other contracts	(4)	(5)
Total derivative liabilities	\$ (930)	(21)

(b) Defined Contribution Plans

The Health System sponsors various defined contribution retirement plans that cover substantially all employees. The plans provide for employer matching contributions in an amount equal to a percentage of employee pretax contributions, up to a maximum amount. In addition, the Health System makes contributions to eligible employees based on years of service. Retirement expense related to these plans was \$478 and \$440 in 2017 and 2016, respectively, and is reflected in salaries and benefit expense in the accompanying combined statements of operations.

(6) Commitments and Contingencies

(a) Commitments

Firm purchase commitments, primarily related to construction and equipment and software acquisition, at December 31, 2017 are approximately \$381.

(b) Operating Leases

The Health System leases various medical and office equipment and buildings under operating leases.

PROVIDENCE ST. JOSEPH HEALTH
Notes to Combined Financial Statements
December 31, 2017 and 2016
(In millions of dollars)

Future minimum lease commitments under noncancelable operating leases for the next five years and thereafter are as follows:

2018	\$	221
2019		204
2020		186
2021		165
2022		144
Thereafter		773
	\$	1,693

Rental expense, including month-to-month leases and contingent rents, was \$382 and \$302 for the years ended December 31, 2017 and 2016, respectively, and is included in other expenses in the accompanying combined statements of operations.

(c) *Litigation*

The healthcare industry is subject to numerous laws and regulations from federal, state, and local governments. Compliance with these laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time. Government monitoring and enforcement activity continues with respect to investigations and allegations concerning possible violations by healthcare providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of patient services previously billed. Institutions within the Health System are subject to similar regulatory reviews.

Management is aware of certain asserted and unasserted legal claims and regulatory matters arising in the course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Health System's combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Supplemental Schedule - Obligated Group Combining Balance Sheets Information

December 31, 2017 and 2016

(In millions of dollars)

Assets	2017			2016		
	Obligated Group	Non Obligated, Eliminations, Other	Total Combined	Obligated Group	Non Obligated, Eliminations, Other	Total Combined
Current assets:						
Cash and cash equivalents	\$ 787	584	1,371	551	449	1,000
Accounts receivable, net	2,148	74	2,222	2,123	83	2,206
Supplies inventory	270	7	277	266	13	279
Other current assets	1,103	54	1,157	1,378	(209)	1,169
Current portion of assets whose use is limited	256	224	480	492	274	766
Total current assets	4,564	943	5,507	4,810	610	5,420
Assets whose use is limited	7,580	2,406	9,986	6,820	1,911	8,731
Property, plant, and equipment, net	10,496	459	10,955	10,561	461	11,022
Other assets	1,732	(535)	1,197	1,594	(476)	1,118
Total assets	\$ 24,372	3,273	27,645	23,785	2,506	26,291
Liabilities and Net Assets						
Current liabilities:						
Current portion of long-term debt	\$ 76	2	78	194	6	200
Master trust debt classified as short-term	57	—	57	153	—	153
Accounts payable	624	60	684	506	126	632
Accrued compensation	1,033	78	1,111	1,026	78	1,104
Other current liabilities	1,623	668	2,291	1,289	574	1,863
Total current liabilities	3,413	808	4,221	3,168	784	3,952
Long-term debt, net of current portion	6,457	28	6,485	6,377	19	6,396
Pension benefit obligation	1,054	—	1,054	1,120	—	1,120
Other liabilities	509	630	1,139	535	492	1,027
Total liabilities	11,433	1,466	12,899	11,200	1,295	12,495
Net assets:						
Unrestricted	12,178	1,367	13,545	11,921	839	12,760
Temporarily restricted	622	336	958	535	281	816
Permanently restricted	139	104	243	129	91	220
Total net assets	12,939	1,807	14,746	12,585	1,211	13,796
Total liabilities and net assets	\$ 24,372	3,273	27,645	23,785	2,506	26,291

See accompanying independent auditors' report

PROVIDENCE ST. JOSEPH HEALTH

Supplemental Schedule – Obligated Group Combining Statements of Operations Information

Years ended December 31, 2017 and 2016

(In millions of dollars)

	2017			2016		
	Obligated Group	Non Obligated, Eliminations, Other	Total Combined	Obligated Group	Non Obligated, Eliminations, Other	Total Combined
Operating revenues:						
Net patient service revenues	\$ 17,630	506	18,136	13,615	1,357	14,972
Provision for bad debts	(243)	(26)	(269)	(150)	(53)	(203)
Net patient service revenues less provision for bad debts	17,387	480	17,867	13,465	1,304	14,769
Other revenues	1,844	3,452	5,296	1,147	2,963	4,110
Total operating revenues	19,231	3,932	23,163	14,612	4,267	18,879
Operating expenses:						
Salaries and benefits	10,391	1,073	11,464	8,199	1,400	9,599
Supplies	3,194	196	3,390	2,419	369	2,788
Interest, depreciation, and amortization	1,232	75	1,307	897	169	1,066
Purchased services, professional fees, and other	3,827	3,172	6,999	2,957	2,718	5,675
Total operating expenses	18,644	4,516	23,160	14,472	4,656	19,128
Excess (deficit) of revenues over expenses from operations	587	(584)	3	140	(389)	(249)
Net nonoperating gains (losses):						
Contributions from affiliations	—	—	—	—	5,167	5,167
Loss on extinguishment of debt	—	—	—	(60)	—	(60)
Investment income, net	773	109	882	277	126	403
Other	(4)	(101)	(105)	(12)	(18)	(30)
Total net nonoperating gains	769	8	777	205	5,275	5,480
Excess of revenues over expenses	\$ 1,356	(576)	780	345	4,886	5,231

See accompanying independent auditors' report.

Appendix 2

Audited Financials

Kindred Healthcare, Inc. – 2016, 2017

Kindred Healthcare, LLC – 2018

**UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549**

FORM 10-K

(Mark One)

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2016

OR

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

Commission File Number: 001-14057

KINDRED HEALTHCARE, INC.

(Exact name of registrant as specified in its charter)

Delaware
(State or other jurisdiction of
incorporation or organization)

61-1323993
(I.R.S. Employer
Identification Number)

680 South Fourth Street
Louisville, Kentucky
(Address of principal executive offices)

40202-2412
(Zip Code)

(502) 596-7300

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

<u>Title of Each Class</u>	<u>Name of Each Exchange on which Registered</u>
Common Stock, par value \$0.25 per share	New York Stock Exchange

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Annual Report on Form 10-K or any amendment of this Annual Report on Form 10-K.

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer Accelerated filer Non-accelerated filer Smaller reporting company

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes No

The aggregate market value of the shares of the registrant held by non-affiliates of the registrant, based on the closing price of such stock on the New York Stock Exchange on June 30, 2016, was approximately \$935,800,000. For purposes of the foregoing calculation only, all directors and executive officers of the registrant have been deemed affiliates.

As of January 31, 2017, there were 85,127,745 shares of the registrant's common stock, \$0.25 par value, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Annual Report on Form 10-K incorporates by reference from the registrant's 2016 definitive proxy statement, which will be filed no later than 120 days after December 31, 2016.

TABLE OF CONTENTS

	<u>Page</u>
<u>PART I</u>	
Item 1. Business	5
Item 1A. Risk Factors	44
Item 1B. Unresolved Staff Comments	63
Item 2. Properties	64
Item 3. Legal Proceedings	64
Item 4. Mine Safety Disclosures	64
<u>PART II</u>	
Item 5. Market for Registrant’s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities	65
Item 6. Selected Financial Data	67
Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations	69
Item 7A. Quantitative and Qualitative Disclosures About Market Risk	97
Item 8. Financial Statements and Supplementary Data	98
Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure	98
Item 9A. Controls and Procedures	98
Item 9B. Other Information	98
<u>PART III</u>	
Item 10. Directors, Executive Officers and Corporate Governance	99
Item 11. Executive Compensation	100
Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters	100
Item 13. Certain Relationships and Related Transactions, and Director Independence	100
Item 14. Principal Accounting Fees and Services	100
<u>PART IV</u>	
Item 15. Exhibits and Financial Statement Schedules	101
Item 16. Form 10-K Summary	101

PART IV

Item 15. Exhibits and Financial Statement Schedules

(a)(1) Index to Consolidated Financial Statements:

	<u>Page</u>
Report of Independent Registered Public Accounting Firm	F-2
Consolidated Financial Statements:	
Consolidated Statement of Operations for the years ended December 31, 2016, 2015 and 2014	F-3
Consolidated Statement of Comprehensive Loss for the years ended December 31, 2016, 2015 and 2014	F-4
Consolidated Balance Sheet, December 31, 2016 and 2015	F-5
Consolidated Statement of Equity for the years ended December 31, 2016, 2015 and 2014	F-6
Consolidated Statement of Cash Flows for the years ended December 31, 2016, 2015 and 2014	F-7
Notes to Consolidated Financial Statements	F-8
Quarterly Consolidated Financial Information (Unaudited)	F-67

(a)(2) Index to Financial Statement Schedules:

Financial Statement Schedule (a):	
Schedule II – Valuation and Qualifying Accounts for the years ended December 31, 2016, 2015 and 2014	F-69

(a) All other schedules have been omitted because the required information is not present or not present in material amounts.

Item 16. Form 10-K Summary

None.

KINDRED HEALTHCARE, INC.
INDEX TO CONSOLIDATED FINANCIAL STATEMENTS
AND FINANCIAL STATEMENT SCHEDULES

	<u>Page</u>
<u>Report of Independent Registered Public Accounting Firm</u>	F-2
Consolidated Financial Statements:	
<u>Consolidated Statement of Operations for the years ended December 31, 2016, 2015 and 2014</u>	F-3
<u>Consolidated Statement of Comprehensive Loss for the years ended December 31, 2016, 2015 and 2014</u>	F-4
<u>Consolidated Balance Sheet, December 31, 2016 and 2015</u>	F-5
<u>Consolidated Statement of Equity for the years ended December 31, 2016, 2015 and 2014</u>	F-6
<u>Consolidated Statement of Cash Flows for the years ended December 31, 2016, 2015 and 2014</u>	F-7
<u>Notes to Consolidated Financial Statements</u>	F-8
<u>Quarterly Consolidated Financial Information (Unaudited)</u>	F-67
Financial Statement Schedule (a):	
<u>Schedule II – Valuation and Qualifying Accounts for the years ended December 31, 2016, 2015 and 2014</u>	F-69

(a) All other schedules have been omitted because the required information is not present or not present in material amounts.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Shareholders
of Kindred Healthcare, Inc.:

In our opinion, the consolidated financial statements listed in the index appearing under Item 15(a)(1) present fairly, in all material respects, the financial position of Kindred Healthcare, Inc. and its subsidiaries at December 31, 2016 and 2015, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2016 in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the financial statement schedule listed in the index appearing under Item 15(a)(2) presents fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2016, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these financial statements and financial statement schedule, for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Annual Report on Internal Control over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on these financial statements, on the financial statement schedule, and on the Company's internal control over financial reporting based on our integrated audits. We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ PRICEWATERHOUSECOOPERS LLP

Louisville, Kentucky
February 28, 2017

KINDRED HEALTHCARE, INC.
CONSOLIDATED STATEMENT OF OPERATIONS

(In thousands, except per share amounts)

	Year ended December 31,		
	2016	2015	2014
Revenues	\$ 7,219,519	\$ 7,054,907	\$ 5,027,599
Salaries, wages and benefits	3,758,423	3,614,091	2,442,879
Supplies	384,098	384,354	289,043
Rent	390,534	379,889	312,792
Other operating expenses	845,680	825,996	679,992
General and administrative expenses (exclusive of depreciation and amortization expense included below)	1,303,428	1,385,038	969,035
Other income	(2,900)	(3,016)	(872)
Litigation contingency expense	2,840	138,648	4,600
Impairment charges	342,559	24,757	-
Restructuring charges	107,175	12,970	4,435
Depreciation and amortization	159,402	157,251	155,570
Interest expense	234,647	232,395	168,763
Investment income	(3,162)	(2,806)	(3,996)
	<u>7,522,724</u>	<u>7,149,567</u>	<u>5,022,241</u>
Income (loss) from continuing operations before income taxes	(303,205)	(94,660)	5,358
Provision (benefit) for income taxes	314,330	(42,797)	462
Income (loss) from continuing operations	(617,535)	(51,863)	4,896
Discontinued operations, net of income taxes:			
Income (loss) from operations	6,616	(235)	(53,630)
Gain (loss) on divestiture of operations	295	1,244	(12,698)
Income (loss) from discontinued operations	6,911	1,009	(66,328)
Net loss	(610,624)	(50,854)	(61,432)
(Earnings) loss attributable to noncontrolling interests:			
Continuing operations	(53,602)	(42,564)	(18,872)
Discontinued operations	(4)	34	467
	<u>(53,606)</u>	<u>(42,530)</u>	<u>(18,405)</u>
Loss attributable to Kindred	<u>\$ (664,230)</u>	<u>\$ (93,384)</u>	<u>\$ (79,837)</u>
Amounts attributable to Kindred stockholders:			
Loss from continuing operations	\$ (671,137)	\$ (94,427)	\$ (13,976)
Income (loss) from discontinued operations	6,907	1,043	(65,861)
Net loss	<u>\$ (664,230)</u>	<u>\$ (93,384)</u>	<u>\$ (79,837)</u>
Loss per common share:			
Basic:			
Loss from continuing operations	\$ (7.73)	\$ (1.12)	\$ (0.24)
Discontinued operations:			
Income (loss) from operations	0.08	-	(0.91)
Gain (loss) on divestiture of operations	-	0.01	(0.21)
Income (loss) from discontinued operations	0.08	0.01	(1.12)
Net loss	<u>\$ (7.65)</u>	<u>\$ (1.11)</u>	<u>\$ (1.36)</u>
Diluted:			
Loss from continuing operations	\$ (7.73)	\$ (1.12)	\$ (0.24)
Discontinued operations:			
Income (loss) from operations	0.08	-	(0.91)
Gain (loss) on divestiture of operations	-	0.01	(0.21)
Income (loss) from discontinued operations	0.08	0.01	(1.12)
Net loss	<u>\$ (7.65)</u>	<u>\$ (1.11)</u>	<u>\$ (1.36)</u>
Shares used in computing loss per common share:			
Basic	86,800	84,558	58,634
Diluted	86,800	84,558	58,634
Cash dividends declared and paid per common share	\$ 0.48	\$ 0.48	\$ 0.48

See accompanying notes.

KINDRED HEALTHCARE, INC.
CONSOLIDATED STATEMENT OF COMPREHENSIVE LOSS
(In thousands)

	Year ended December 31,		
	2016	2015	2014
Net loss	\$ (610,624)	\$ (50,854)	\$ (61,432)
Other comprehensive income (loss):			
Available-for-sale securities (Note 12):			
Change in unrealized investment gains (losses)	1,636	(133)	1,007
Reclassification of gains realized in net loss	(1,206)	(173)	(2,803)
Net change	430	(306)	(1,796)
Interest rate swaps (Notes 1 and 14):			
Change in unrealized gains (losses)	1,755	(799)	(2,237)
Reclassification of ineffectiveness realized in net loss	-	146	227
Reclassification of losses realized in net loss, net of payments	411	-	809
Net change	2,166	(653)	(1,201)
Defined benefit post-retirement plan:			
Unrealized gain (loss) due to fair value adjustments	220	753	(1,337)
Income tax benefit related to items of other comprehensive income (loss)	1,389	125	2,035
Other comprehensive income (loss)	4,205	(81)	(2,299)
Comprehensive loss	(606,419)	(50,935)	(63,731)
Earnings attributable to noncontrolling interests	(53,606)	(42,530)	(18,405)
Comprehensive loss attributable to Kindred	<u>\$ (660,025)</u>	<u>\$ (93,465)</u>	<u>\$ (82,136)</u>

See accompanying notes.

KINDRED HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEET
(In thousands, except per share amounts)

	December 31, 2016	December 31, 2015
ASSETS		
Current assets:		
Cash and cash equivalents	\$ 137,061	\$ 98,758
Insurance subsidiary investments	108,966	106,638
Accounts receivable less allowance for loss of \$71,070 — 2016 and \$62,896 — 2015	1,172,078	1,194,868
Inventories	24,673	27,791
Income taxes	10,067	11,790
Other	63,693	61,054
	<u>1,516,538</u>	<u>1,500,899</u>
Property and equipment, at cost:		
Land	82,008	86,529
Buildings	971,086	1,046,341
Equipment	932,873	979,132
Construction in progress	40,463	50,396
	<u>2,026,430</u>	<u>2,162,398</u>
Accumulated depreciation	<u>(1,147,844)</u>	<u>(1,190,402)</u>
	878,586	971,996
Goodwill	2,427,074	2,669,810
Intangible assets less accumulated amortization of \$102,580 — 2016 and \$94,221 — 2015	790,235	755,655
Insurance subsidiary investments	204,929	204,498
Deferred tax assets	-	104,130
Acquisition deposit	-	18,489
Other	295,362	242,782
Total assets (a)	<u>\$ 6,112,724</u>	<u>\$ 6,468,259</u>
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	\$ 203,925	\$ 187,061
Salaries, wages and other compensation	397,486	404,925
Due to third party payors	41,320	36,251
Professional liability risks	65,284	64,099
Other accrued liabilities	269,736	394,246
Long-term debt due within one year	27,977	24,630
	<u>1,005,728</u>	<u>1,111,212</u>
Long-term debt	3,215,062	3,086,348
Professional liability risks	295,311	263,273
Deferred tax liabilities	201,808	-
Deferred credits and other liabilities	353,294	301,379
Commitments and contingencies (Note 16)		
Equity:		
Stockholder's equity:		
Common stock, \$0.25 par value; authorized 175,000 shares; issued 85,166 shares — 2016 and 83,792 shares — 2015	21,291	20,948
Capital in excess of par value	1,710,231	1,737,747
Accumulated other comprehensive income (loss)	1,573	(2,632)
Accumulated deficit	<u>(920,544)</u>	<u>(256,209)</u>
	812,551	1,499,854
Noncontrolling interests	228,970	206,193
Total equity	<u>1,041,521</u>	<u>1,706,047</u>
Total liabilities (a) and equity	<u>\$ 6,112,724</u>	<u>\$ 6,468,259</u>

(a) The Company's consolidated assets as of December 31, 2016 and 2015 include total assets of variable interest entities of \$394 million and \$389 million, respectively, which can only be used to settle the obligations of the variable interest entities. The Company's consolidated liabilities as of December 31, 2016 and 2015 include total liabilities of variable interest entities of \$39 million and \$40 million, respectively. See note 1 of the notes to consolidated financial statements.

See accompanying notes.

KINDRED HEALTHCARE, INC.
CONSOLIDATED STATEMENT OF EQUITY
(In thousands)

	Attributable to Kindred stockholders						Noncontrolling interests	Total
	Shares of common stock	Par value common stock	Capital in excess of par value	Accumulated other comprehensive income (loss)	Accumulated deficit	Total		
Balances, December 31, 2013	54,165	\$ 13,541	\$ 1,146,193	\$ (252)	\$ (76,825)	\$ 38,559	\$ 1,121,216	
Comprehensive loss:								
Net income (loss)					(79,837)	18,405	(61,432)	
Net unrealized investment losses, net of income taxes				(1,167)			(1,167)	
Other				(1,132)			(1,132)	
Comprehensive loss							(63,731)	
Grant of non-vested restricted stock	473	118	(118)				-	
Issuance of common stock in connection with employee benefit plans	511	128	6,590		(475)		6,243	
Shares tendered by employees for statutory tax withholdings upon issuance of common stock	(291)	(73)	(3,580)		(2,631)		(6,284)	
Stock-based compensation amortization			16,643				16,643	
Income tax provision in connection with the issuance of common stock under employee benefit plans			(801)				(801)	
Equity offerings, net of costs	15,119	3,780	317,570				321,350	
Tangible equity units offering, net of costs			132,789				132,789	
Contribution made by noncontrolling interests						833	833	
Distributions to noncontrolling interests						(13,692)	(13,692)	
Dividends paid			(28,594)				(28,594)	
Balances, December 31, 2014	69,977	17,494	1,586,692	(2,551)	(159,768)	44,105	1,485,972	
Comprehensive loss:								
Net income (loss)					(93,384)	42,530	(50,854)	
Net unrealized investment losses, net of income taxes				(199)			(199)	
Other				118			118	
Comprehensive loss							(50,935)	
Grant of non-vested restricted stock	672	168	(168)				-	
Issuance of common stock in connection with employee benefit plans	216	54	482		(2)		534	
Shares tendered by employees for statutory tax withholdings upon issuance of common stock	(481)	(120)	(7,050)		(3,055)		(10,225)	
Stock-based compensation amortization			20,636				20,636	
Income tax benefit in connection with the issuance of common stock under employee benefit plans			3,170				3,170	
Exchange of tangible equity units, net of costs	3,668	917	(917)				-	
Contributions made by noncontrolling interests						8,132	8,132	
Distributions to noncontrolling interests						(42,458)	(42,458)	
Purchase of noncontrolling interests						153,884	153,884	
Dividends paid			(40,119)				(40,119)	
Issuance of common stock in Gentiva Merger	9,740	2,435	175,021				177,456	
Balances, December 31, 2015	83,792	20,948	1,737,747	(2,632)	(256,209)	206,193	1,706,047	
Comprehensive loss:								
Net income (loss)					(664,230)	53,606	(610,624)	
Net unrealized investment gains, net of income taxes				339			339	
Other				3,866			3,866	
Comprehensive loss							(606,419)	
Grant of non-vested restricted stock	1,384	346	(346)				-	
Issuance of common stock in connection with employee benefit plans	292	73	(73)				-	
Shares tendered by employees for statutory tax withholdings upon issuance of common stock	(302)	(76)	(2,985)		(105)		(3,166)	
Stock-based compensation amortization			16,425				16,425	
Income tax benefit in connection with the issuance of common stock under employee benefit plans			435				435	
Contributions made by noncontrolling interests						17,314	17,314	
Distributions to noncontrolling interests						(45,985)	(45,985)	
Purchase of noncontrolling interests			(234)			(2,158)	(2,392)	
Dividends paid			(40,738)				(40,738)	
Balances, December 31, 2016	85,166	\$ 21,291	\$ 1,710,231	\$ 1,573	\$ (920,544)	\$ 228,970	\$ 1,041,521	

See accompanying notes.

KINDRED HEALTHCARE, INC.
CONSOLIDATED STATEMENT OF CASH FLOWS
(In thousands)

	Year ended December 31,		
	2016	2015	2014
Cash flows from operating activities:			
Net loss	\$ (610,624)	\$ (50,854)	\$ (61,432)
Adjustments to reconcile net loss to net cash provided by operating activities:			
Depreciation expense	135,966	128,533	139,284
Amortization of intangible assets	23,673	29,841	21,666
Amortization of stock-based compensation costs	16,425	20,636	16,643
Amortization of deferred financing costs	15,267	13,721	23,288
Payment of capitalized lender fees related to debt issuance	(7,375)	(28,012)	(22,652)
Provision for doubtful accounts	40,804	52,460	41,803
Deferred income taxes	310,338	(46,632)	(35,615)
Impairment charges	342,559	24,757	673
(Gain) loss on divestiture of discontinued operations	(295)	(1,244)	12,698
Other	12,414	13,537	2,336
Change in operating assets and liabilities:			
Accounts receivable	(59,031)	(8,577)	(74,378)
Inventories and other assets	(24,226)	54,493	(25,960)
Accounts payable	26,215	(10,380)	(9,399)
Income taxes	4,242	27,392	31,728
Due to third party payors	3,692	(30,882)	11,177
Other accrued liabilities	(45,082)	(25,527)	33,611
Net cash provided by operating activities	<u>184,962</u>	<u>163,262</u>	<u>105,471</u>
Cash flows from investing activities:			
Routine capital expenditures	(96,052)	(121,931)	(91,081)
Development capital expenditures	(34,825)	(19,931)	(5,257)
Acquisitions, net of cash acquired	(78,840)	(673,547)	(24,136)
Acquisition deposits	18,489	176,511	(195,000)
Sale of assets	25,987	8,735	23,861
Proceeds from senior unsecured notes offering held in escrow	-	1,350,000	(1,350,000)
Interest in escrow for senior unsecured notes	-	23,438	(23,438)
Purchase of insurance subsidiary investments	(97,740)	(85,222)	(105,324)
Sale of insurance subsidiary investments	95,488	75,075	51,716
Net change in insurance subsidiary cash and cash equivalents	877	(12,271)	33,683
Proceeds from note receivable	-	25,000	-
Net change in other investments	(32,770)	(4,620)	1,406
Other	(255)	10,972	679
Net cash provided by (used in) investing activities	<u>(199,641)</u>	<u>752,209</u>	<u>(1,682,891)</u>
Cash flows from financing activities:			
Proceeds from borrowings under revolving credit	1,643,300	1,740,450	1,551,515
Repayment of borrowings under revolving credit	(1,689,400)	(1,631,850)	(1,807,615)
Proceeds from issuance of term loan, net of discount	198,100	199,000	997,500
Proceeds from issuance of senior unsecured notes due 2022	-	-	500,000
Proceeds from issuance of senior unsecured notes due 2020 and 2023	-	-	1,350,000
Proceeds from issuance of debt component of tangible equity units	-	-	34,773
Proceeds from other long-term debt	750	-	-
Repayment of Gentiva debt	-	(1,177,363)	-
Repayment of senior unsecured notes	-	-	(550,000)
Repayment of term loan	(13,527)	(12,010)	(788,563)
Repayment of other long-term debt	(1,104)	(6,752)	(273)
Payment of deferred financing costs	(522)	(3,446)	(3,431)
Equity offering, net of offering costs	-	-	321,968
Issuance of equity component of tangible equity units, net of issuance costs	-	-	133,336
Issuance of common stock in connection with employee benefit plans	-	534	6,243
Payment of costs associated with issuance of common stock and tangible equity units	-	(915)	-
Payment of dividend for mandatory redeemable preferred stock	(11,514)	(10,887)	-
Dividends paid	(40,738)	(40,119)	(28,594)
Contributions made by noncontrolling interests	14,514	2,152	-
Distributions to noncontrolling interests	(45,985)	(42,458)	(13,692)
Purchase of noncontrolling interests	(1,000)	-	-
Other	108	2,763	2,469
Net cash provided by (used in) financing activities	<u>52,982</u>	<u>(980,901)</u>	<u>1,705,636</u>
Change in cash and cash equivalents	38,303	(65,430)	128,216
Cash and cash equivalents at beginning of period	98,758	164,188	35,972
Cash and cash equivalents at end of period	<u>\$ 137,061</u>	<u>\$ 98,758</u>	<u>\$ 164,188</u>
Supplemental information:			
Interest payments	\$ 216,062	\$ 180,266	\$ 120,504
Income tax refunds	253	26,473	29,297
Rental payments to Ventas, Inc.	167,743	171,829	192,144
Issuance of common stock in Gentiva Merger (see Note 2)	-	177,456	-
Non-cash contributions made by noncontrolling interests	2,800	5,980	833

See accompanying notes.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1 – BASIS OF PRESENTATION

Reporting entity

Kindred Healthcare, Inc. is a healthcare services company that through its subsidiaries operates a home health, hospice, and community care business, transitional care (“TC”) hospitals, inpatient rehabilitation hospitals (“IRFs”), a contract rehabilitation services business, nursing centers, and assisted living facilities across the United States (collectively, the “Company” or “Kindred”).

Basis of presentation

The consolidated financial statements include all subsidiaries that the Company controls, including variable interest entities (“VIEs”) for which the Company is the primary beneficiary. All intercompany transactions have been eliminated.

The Company has completed several transactions related to the divestiture of unprofitable hospitals and nursing centers to improve its future operating results. For accounting purposes, the operating results of these businesses and the gains, losses or impairments associated with these transactions have been classified as discontinued operations in the accompanying consolidated statement of operations for all periods presented in accordance with the authoritative guidance in effect through December 31, 2014. Effective January 1, 2015, the authoritative guidance modified the requirements for reporting discontinued operations. A disposal is now required to be reported in discontinued operations only if the disposal represents a strategic shift that has (or will have) a major effect on the Company’s operations and financial results.

The consolidated financial statements have been prepared in accordance with generally accepted accounting principles (“GAAP”) and include amounts based upon the estimates and judgments of management. Actual amounts may differ from those estimates.

Recently issued accounting requirements

In January 2017, the Financial Accounting Standards Board (the “FASB”) issued authoritative guidance that simplifies the measurement of goodwill impairment to a single-step test. The guidance removes step two of the goodwill impairment test, which requires a hypothetical purchase price allocation, and will now be the amount by which a reporting unit’s carrying value exceeds its fair value, not to exceed the carrying amount of goodwill. Under the revised guidance, failing step one will always result in goodwill impairment. The new guidance is effective for annual and interim goodwill impairment tests beginning after December 15, 2019 and early adoption is permitted. The Company will early adopt the new guidance in the first quarter of 2017 on a prospective basis. If the Company fails step one of the goodwill impairment test under the new guidance, the results could materially impact the Company’s financial position and results of operations but not its business or liquidity.

In January 2017, the FASB issued authoritative guidance that revises the definition of a business, which affects accounting for acquisitions, disposals, goodwill impairment, and consolidation. The guidance is intended to help entities evaluate whether transactions should be accounted for as acquisitions (or disposals) of assets or businesses. The revision provides a more robust framework to use in determining when a set of assets and activities is a business. The new guidance is effective for annual and interim periods beginning after December 15, 2017 and early adoption is permitted. The adoption of this standard is not expected to have a material impact on the Company’s business, financial position, results of operations or liquidity.

In November 2016, the FASB issued authoritative guidance that simplifies the disclosure of restricted cash within the statement of cash flows. The guidance is intended to reduce diversity when reporting restricted cash and requires entities to explain changes in the combined total of restricted and unrestricted balances in the statement of cash flows. The new guidance is effective for annual and interim periods beginning after December 15, 2017 and early adoption is permitted. The adoption of this standard is not expected to have a material impact on the Company’s consolidated statement of cash flows.

In October 2016, the FASB issued authoritative guidance which alters how an entity needs to consider indirect interests in a VIE held through an entity under common control. The amendment eliminates the distinction between the full attribution and proportionate approach, leaving the entity to only consider the latter when evaluating a VIE held through common control. The new guidance is effective for annual and interim periods beginning after December 15, 2016. The adoption of this standard is not expected to have a material impact on the Company’s business, financial position, results of operations or liquidity.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Recently issued accounting requirements (Continued)

In August 2016, the FASB issued authoritative guidance to eliminate diversity in practice related to the cash flow statement classification of eight specific cash flow issues, which include debt prepayment or extinguishment costs, maturity of a zero coupon bond, settlement of contingent consideration liabilities after a business combination, proceeds from insurance settlements and distribution from certain equity method investees. The new guidance is effective for annual and interim periods beginning after December 15, 2017 and early adoption is permitted. The Company is currently assessing the impact on its consolidated statement of cash flows.

In June 2016, the FASB issued authoritative guidance for accounting for credit losses on financial instruments. The new guidance introduces an approach based on expected losses to estimate credit losses on certain types of financial instruments and modifies the impairment model for available-for-sale debt securities. The new guidance is effective for annual periods beginning after December 15, 2019 and early adoption is permitted beginning after December 15, 2018. The Company is still evaluating its transition approach and the impact of adoption on its business, financial position, results of operations, and liquidity.

In March 2016, the FASB issued authoritative guidance that requires the tax effects related to share-based payments to be recorded through the income statement at settlement. Under the new guidance, tax benefits in excess of or less than the tax effect of compensation expenses will no longer be recorded in equity for purpose of simplification, which is expected to reduce administrative complexities but could increase the volatility of income tax expense. The new guidance is effective for annual and interim periods beginning after December 15, 2016. The adoption of this standard will increase the volatility of the Company's income tax provision in its results of operations but is not expected to have a material impact on the Company's business, financial position, or liquidity.

In March 2016, the FASB issued authoritative guidance that eliminates the requirement to apply the equity method of accounting retrospectively when a reporting entity obtains significant influence over a previously held investment. Under the new guidance, the equity method of accounting should be applied prospectively from the date significant influence is obtained. The new guidance is effective for annual and interim periods beginning after December 15, 2016. The adoption of this standard is not expected to have a material impact on the Company's business, financial position, results of operations, or liquidity.

In March 2016, the FASB issued authoritative guidance clarifying that a change in the counterparty to a derivative contract, in and of itself, does not require the dedesignation of a hedging relationship. Under the new guidance, an entity will still need to evaluate whether it is possible that the counterparty will perform under the contract as part of the assessment for hedge accounting. The new guidance is effective for annual and interim periods beginning after December 15, 2016. The adoption of this standard is not expected to have a material impact on the Company's business, financial position, results of operations, or liquidity.

In February 2016, the FASB issued amended authoritative guidance on accounting for leases. The new provisions require that a lessee of operating leases recognize in the statement of financial position a liability to make lease payments (the lease liability) and a right-of-use asset representing its right to use the underlying asset for the lease term. The lease liability will be equal to the present value of lease payments, with the right-of-use asset based upon the lease liability. The classification criteria for distinguishing between finance (or capital) leases and operating leases are substantially similar to the previous lease guidance, but with no explicit bright lines. As such, operating leases will result in straight-line rent expense similar to current practice. For short term leases (term of 12 months or less), a lessee is permitted to make an accounting election not to recognize lease assets and lease liabilities, which would generally result in lease expense being recognized on a straight-line basis over the lease term. The guidance is effective for annual and interim periods beginning after December 15, 2018, and will require application of the new guidance at the beginning of the earliest comparable period presented. The Company will not elect early adoption and will apply the modified retrospective approach as required. The adoption of this standard is expected to have a material impact on the Company's financial position. The Company is still evaluating the impact on its results of operations and there is no impact on liquidity.

In January 2016, the FASB issued amended authoritative guidance which makes targeted improvements for financial instruments. The new provisions impact certain aspects of recognition, measurement, presentation and disclosure requirements of financial instruments. Specifically, the guidance will (i) require equity investments to be measured at fair value with changes in fair value recognized in net income, (ii) simplify the impairment assessment of equity investments without readily determinable fair values, (iii) eliminate the requirement to disclose the method and assumptions used to estimate fair value for financial instruments measured at amortized cost, and (iv) require separate presentation of financial assets and financial liabilities by measurement category. The guidance is effective for annual and interim periods beginning after December 15, 2017, and early adoption is not permitted. The adoption of this standard is not expected to have a material impact on the Company's business, financial position, results of operations or liquidity.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION

Recently issued accounting requirements (Continued)

In August 2014, the FASB issued authoritative guidance requiring management to evaluate whether there are conditions and events that raise substantial doubt about the entity’s ability to continue as a going concern and to provide disclosures in certain circumstances. The guidance is effective for annual and interim periods ending after December 15, 2016. This guidance did not have a material impact on the Company’s consolidated financial statements.

In May 2014, the FASB issued authoritative guidance which changes the requirements for recognizing revenue when entities enter into contracts with customers. Under the new provisions, an entity will recognize revenue when it transfers promised goods or services to customers in an amount that reflects what it expects in exchange for the goods or services. It also requires more detailed disclosures to enable users of financial statements to understand the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers.

- In July 2015, the FASB finalized a one year deferral of the new revenue standard with an updated effective date for interim and annual periods beginning on or after December 15, 2017. Entities are not permitted to adopt the standard earlier than the original effective date, which was on or after December 15, 2016.
- In March 2016, the FASB finalized its amendments to the guidance in the new revenue standard on assessing whether an entity is a principal or an agent in a revenue transaction. Under the new amendments, the FASB confirmed that a principal in an arrangement controls a good or service before it is transferred to a customer but revised the structure of indicators when an entity is the principal. The amendments have the same effective date and transition requirements as the new revenue standard.
- In May 2016, the FASB finalized its amendments to the guidance in the new revenue standard on contracts with customers and specifically, collectability, non-cash consideration, presentation of sales taxes, and completed contracts. The amendments are intended to reduce the risk of diversity in practice and the cost and complexity of applying certain aspects of the revenue standard. The amendments have the same effective date and transition requirements as the new revenue standard, which is effective for interim and annual periods beginning on or after December 15, 2017, with early adoption permitted on or after December 15, 2016.

The Company will not elect early adoption but will apply the modified retrospective approach upon the required effective date. The Company is still evaluating the impact of the adoption of the new revenue standard on its business, financial position, results of operations, and liquidity.

Reclassifications

Certain prior year amounts have been reclassified to conform with the current year presentation.

Correction of December 31, 2015 balance sheet

During the second quarter ended June 30, 2016, the Company corrected the balance sheet presentation of capitalized lender fees related to debt issuance. These amounts were previously presented as other long-term assets in the Company’s consolidated balance sheet, and the Company has determined that they should have been presented as a contra account to long-term debt similar to a debt discount.

The impact of this correction on the Company’s consolidated balance sheet as of December 31, 2015 was as follows:

	As previously reported	Adjustment	As revised
Other long-term assets	\$ 289,746	\$ (46,964)	\$ 242,782
Total assets	6,515,223	(46,964)	6,468,259
Long-term debt	3,133,312	(46,964)	3,086,348
Total liabilities and equity	6,515,223	(46,964)	6,468,259

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Revenues

Revenues are recorded based upon estimated amounts due from patients and third party payors for healthcare services provided, including anticipated settlements under reimbursement agreements with Medicare, Medicaid, Medicare Advantage and other third party payors. Revenues under third party agreements are subject to examination and retroactive adjustment. Provisions for estimated third party adjustments are provided in the period the related services are rendered. Differences between the amounts accrued and subsequent settlements are recorded in the periods the interim or final settlements are determined.

A summary of revenues by payor type follows (in thousands):

	Year ended December 31,		
	2016	2015	2014
Medicare	\$ 3,743,595	\$ 3,605,852	\$ 2,087,261
Medicaid	821,651	817,713	601,645
Medicare Advantage	548,522	530,012	374,431
Medicaid Managed	260,403	207,900	127,707
Other	<u>2,055,193</u>	<u>2,131,012</u>	<u>2,051,812</u>
	7,429,364	7,292,489	5,242,856
Eliminations	<u>(209,845)</u>	<u>(237,582)</u>	<u>(215,257)</u>
	<u>\$ 7,219,519</u>	<u>\$ 7,054,907</u>	<u>\$ 5,027,599</u>

Cash and cash equivalents

Cash and cash equivalents include highly liquid investments with an original maturity of three months or less when purchased. The Company reclassifies outstanding checks in excess of funds on deposit. As of December 31, 2016, \$44.0 million was reclassified to accounts payable and \$4.9 million was reclassified to salaries, wages and other compensation. As of December 31, 2015, \$46.7 million was reclassified to accounts payable and \$3.6 million was reclassified to salaries, wages and other compensation.

Insurance subsidiary investments

The Company maintains investments for the payment of claims and expenses related to professional liability and workers compensation risks. These investments have been categorized as available-for-sale and are reported at fair value. The fair value of publicly traded debt and equity securities and money market funds are based upon quoted market prices or observable inputs such as interest rates using either a market or income valuation approach. Since the Company's insurance subsidiary investments are restricted for a limited purpose, they are classified in the accompanying consolidated balance sheet based upon the expected current and long-term cash requirements of the limited purpose insurance subsidiary.

The Company follows the authoritative guidance related to the meaning of other-than-temporary impairment and its application to certain investments to assess whether the Company's investments with unrealized loss positions are other-than-temporarily impaired. Unrealized gains and losses, net of deferred income taxes, are reported as a component of accumulated other comprehensive income (loss). Realized gains and losses and declines in value judged to be other-than-temporary are determined using the specific identification method and are reported in the Company's statement of operations. See Note 12.

Accounts receivable

Accounts receivable consist primarily of amounts due from the Medicare and Medicaid programs, other government programs, managed care health plans, commercial insurance companies, skilled nursing and hospital customers, individual patients and other customers. Estimated provisions for doubtful accounts are recorded to the extent it is probable that a portion or all of a particular account will not be collected.

In evaluating the collectibility of accounts receivable, the Company considers a number of factors, including the age of the accounts, changes in collection patterns, the composition of patient accounts by payor type, the status of ongoing disputes with third party payors and general industry conditions. Actual collections of accounts receivable in subsequent periods may require changes in the estimated provision for loss. Changes in these estimates are charged or credited to the results of operations in the period of change. Based upon the termination of a RehabCare (as defined below) customer and litigation associated with the collection of past due accounts, the Company recorded a provision for doubtful accounts of \$12.9 million in the fourth quarter of 2015.

The provision for doubtful accounts totaled \$41.3 million for 2016, \$55.0 million for 2015 and \$31.1 million for 2014.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Due to third party payors

The Company's TC hospitals, nursing centers and IRFs are required to submit cost reports at least annually to various state and federal agencies administering the respective reimbursement programs. In many instances, interim cash payments to the Company are only an estimate of the amount due for services provided. Any overpayment to the Company arising from the completion of a cost report is recorded as a liability.

Gentiva Health Services, Inc. ("Gentiva") entered into a five-year Corporate Integrity Agreement with the United States Department of Health and Human Services Office of Inspector General (the "OIG") (the "Gentiva CIA"), which became effective on February 15, 2012. The Gentiva CIA imposes monitoring, reporting, certification, oversight and training obligations which the Company, as a result of the Gentiva Merger (as defined in Note 2), must comply. In the event of a breach of the Gentiva CIA, the Company could become liable for payment of certain stipulated penalties, or its Gentiva subsidiaries could be excluded from participation in federal healthcare programs. During 2016, the Company paid stipulated penalties of \$3.1 million for the failure to fully and adequately adhere to the requirements to implement the corrective actions called for in the Gentiva CIA. As of December 31, 2016 and December 31, 2015, the accrual related to the Gentiva CIA totaled \$2.4 million and \$7.8 million, respectively.

The Company entered into a five-year corporate integrity agreement with the OIG on January 11, 2016 (the "RehabCare CIA"). The RehabCare CIA imposes monitoring, auditing (including by an independent review organization), reporting, certification, oversight, screening, and training obligations with which the Company must comply. These obligations include retention of an independent review organization to perform duties under the RehabCare CIA, which include reviewing compliance by RehabCare Group, Inc. and its subsidiaries ("RehabCare"), a therapy services company acquired by the Company on June 1, 2011, with federal program requirements and accepted medical practices, and annual reporting obligations to the OIG regarding RehabCare's compliance with the RehabCare CIA (including corresponding certification by senior management and the Board of Directors or a committee thereof). In the event of a breach of the RehabCare CIA, the Company could become liable for payment of certain stipulated penalties, or RehabCare's subsidiaries could be excluded from participation in federal healthcare programs. The costs associated with compliance with the RehabCare CIA could be substantial and may be greater than the Company currently anticipates.

Any breach or failure to comply with the Gentiva CIA or the RehabCare CIA, the imposition of substantial monetary penalties, or any suspension or exclusion from participation in federal healthcare programs, could have a material adverse effect on the Company's business, financial position, results of operations, and liquidity.

Inventories

Inventories consist primarily of pharmaceutical and medical supplies and are stated at the lower of cost (first-in, first-out) or market.

Property and equipment

Beginning January 1, 2015, the Company changed the estimated useful life of certain technology and medical equipment based upon a detailed review of actual utilization. The change in estimate extended the expected useful life by two to three years depending on the equipment category and has been accounted for prospectively. The impact from this change in accounting estimate was an increase to income (loss) from continuing operations before income taxes of approximately \$14 million (\$8 million net of income taxes) for the year ended December 31, 2015.

Property and equipment is carried at cost less accumulated depreciation. Depreciation expense, computed by the straight-line method, was \$135.7 million for 2016, \$127.4 million for 2015 and \$133.9 million for 2014. These amounts include amortization of assets recorded under capital leases. Depreciation rates for buildings range generally from 20 to 45 years. Leasehold improvements are depreciated over their estimated useful lives or the remaining lease term, whichever is shorter. Estimated useful lives of equipment vary from five to 15 years. Depreciation expense is not recorded for property and equipment classified as held for sale. Repairs and maintenance are expensed as incurred.

The Company separates capital expenditures into two categories, routine and development, in the accompanying consolidated statement of cash flows. Purchases of routine property and equipment include expenditures at existing facilities that generally do not result in increased capacity or the expansion of services. Development capital expenditures include expenditures for the development of new facilities or the expansion of services or capacity at existing facilities.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Long-lived assets

The Company reviews the carrying value of certain long-lived assets and finite lived intangible assets with respect to any events or circumstances that indicate an impairment or an adjustment to the amortization period is necessary. If circumstances suggest that the recorded amounts cannot be recovered based upon estimated future undiscounted cash flows, the carrying values of such assets are reduced to fair value.

In assessing the carrying values of long-lived assets, the Company estimates future cash flows at the lowest level for which there are independent, identifiable cash flows. For this purpose, these cash flows are aggregated based upon the contractual agreements underlying the operation of the facility or group of facilities. Generally, an individual facility for hospitals, IRFs, or nursing centers, skilled nursing rehabilitation services reporting unit, hospital rehabilitation services reporting unit or sites of service within the Kindred at Home division are considered the lowest level for which there are independent, identifiable cash flows. However, to the extent that groups of facilities are leased under a master lease agreement in which the operations of a facility and compliance with the lease terms are interdependent upon other facilities in the agreement (including the Company's ability to renew the lease or divest a particular property), the Company defines the group of facilities under a master lease agreement, or a renewal bundle in a master lease, as the lowest level for which there are independent, identifiable cash flows. Accordingly, the estimated cash flows of all facilities within a master lease agreement, or within a renewal bundle in a master lease, are aggregated for purposes of evaluating the carrying values of long-lived assets.

Impairment charges recorded for the three years ended December 31, 2016 associated with long-lived assets are discussed in Note 4. Losses associated with the disposition or planned disposition of long-lived assets for the three years ended December 31, 2016 are discussed in Note 5.

Goodwill and intangible assets

Goodwill and indefinite-lived intangible assets primarily originated from business combinations accounted for as purchase transactions. Indefinite-lived intangible assets consist of trade names, Medicare certifications and certificates of need.

A summary of goodwill by reporting unit follows (in thousands):

	Home health	Hospice	Community care	Hospitals	Hospital rehabilitation services	IRFs	RehabCare	Nursing centers	Total
Balances, December 31, 2014	\$ 117,589	\$ 26,910	\$ -	\$ 679,480	\$ 173,618	\$ -	\$ -	\$ -	\$ 997,597
Acquisitions	623,441	613,295	166,312	-	-	271,717	-	-	1,674,765
Dispositions	(1,353)	(1,199)	-	-	-	-	-	-	(2,552)
Reclassification	-	-	-	(50,961)	-	50,961	-	-	-
Balances, December 31, 2015	739,677	639,006	166,312	628,519	173,618	322,678	-	-	2,669,810
Acquisitions	6,989	6,627	7,365	23,751	-	2,800	-	-	47,532
Dispositions	-	-	-	(29,831)	-	-	-	-	(29,831)
Impairment charges	-	-	-	(261,129)	-	-	-	-	(261,129)
Other (1)	(647)	696	(214)	-	-	857	-	-	692
Balances, December 31, 2016	<u>\$ 746,019</u>	<u>\$ 646,329</u>	<u>\$ 173,463</u>	<u>\$ 361,310</u>	<u>\$ 173,618</u>	<u>\$ 326,335</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 2,427,074</u>
Accumulated impairment charges:									
December 31, 2015	\$ (76,082)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (153,898)	\$ (6,080)	\$ (236,060)
December 31, 2016	\$ (76,082)	\$ -	\$ -	\$ (261,129)	\$ -	\$ -	\$ (153,898)	\$ (6,080)	\$ (497,189)

(1) Other consists primarily of non-cash adjustments related to acquisitions within the measurement period.

In accordance with the authoritative guidance for goodwill and other intangible assets, the Company is required to perform an impairment test for goodwill and indefinite-lived intangible assets at least annually or more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. The Company performs its annual goodwill impairment test on October 1 each fiscal year for each of its reporting units.

A reporting unit is either an operating segment or one level below the operating segment, referred to as a component. When the components within the Company's operating segments have similar economic characteristics, the Company aggregates the components of its operating segments into one reporting unit. Accordingly, the Company has determined that its reporting units are home health, hospice, community care, hospitals, hospital rehabilitation services, IRFs, RehabCare and nursing centers. The community care reporting unit is included in the home health operating segment of the Kindred at Home division. The hospital rehabilitation services and IRFs reporting units are both included in the Kindred Hospital Rehabilitation Services operating segment of the Kindred Rehabilitation Services division.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Goodwill and intangible assets (Continued)

The goodwill impairment test involves a two-step process. The first step is a comparison of each reporting unit's fair value to its carrying value. If the carrying value of the reporting unit is greater than its fair value, there is an indication that impairment may exist and the second step must be performed to measure the amount of impairment loss, if any. Based upon the results of the step one annual impairment test for goodwill for each of the Company's reporting units at October 1, 2016 and October 1, 2015, no impairment charges were recorded in connection with the Company's annual impairment test. See Note 4 for a discussion of other goodwill impairment charges and triggering events.

Since quoted market prices for the Company's reporting units are not available, the Company applies judgment in determining the fair value of these reporting units for purposes of performing the goodwill impairment test. The Company relies on widely accepted valuation techniques, including discounted cash flow and market multiple analyses approaches, which capture both the future income potential of the reporting unit and the market behaviors and actions of market participants in the industry that includes the reporting unit. These types of analyses require the Company to make assumptions and estimates regarding future cash flows, industry-specific economic factors and the profitability of future business strategies. The discounted cash flow approach uses a projection of estimated operating results and cash flows that are discounted using a weighted average cost of capital. Under the discounted cash flow approach, the projection uses management's best estimates of economic and market conditions over the projected period for each reporting unit including growth rates in the number of admissions, patient days, reimbursement rates, operating costs, rent expense, and capital expenditures. Other significant estimates and assumptions include terminal value growth rates, changes in working capital requirements and weighted average cost of capital. The market multiple analysis estimates fair value by applying cash flow multiples to the reporting unit's operating results. The multiples are derived from comparable publicly traded companies with similar operating and investment characteristics to the reporting units.

Adverse changes in the operating environment and related key assumptions used to determine the fair value of the Company's reporting units and indefinite-lived intangible assets or declines in the value of the Company's Common Stock (as defined below) may result in future impairment charges for a portion or all of these assets. Specifically, if the rate of growth of government and commercial revenues earned by the Company's reporting units were to be less than projected, if healthcare reforms were to negatively impact the Company's business, or if recent increases in labor costs materially exceed the Company's projections in its reporting units or business segments, an impairment charge of a portion or all of these assets may be required. An impairment charge could have a material adverse effect on the Company's business, financial position and results of operations, but would not be expected to have an impact on the Company's cash flows or liquidity.

The Company's indefinite-lived intangible assets consist of trade names, Medicare certifications, and certificates of need. The fair values of the Company's indefinite-lived intangible assets are derived from current market data, including comparable sales or royalty rates, and projections at a facility, geographical location level or reporting unit, which include management's best estimates of economic and market conditions over the projected period. Significant assumptions include growth rates in the number of admissions, patient days, reimbursement rates, operating costs, rent expense, capital expenditures, terminal value growth rates, changes in working capital requirements, weighted average cost of capital and opportunity costs.

The Company performs its annual indefinite-lived intangible asset impairment tests on May 1 and October 1 each fiscal year depending on the indefinite-lived intangible asset. See Note 4 for a discussion of indefinite-lived intangible asset impairment charges recorded during the year ended December 31, 2016 as a result of these impairment tests and other triggering events. Based upon the results of the annual impairment test for indefinite-lived intangible assets discussed above for the years ended December 31, 2015, and 2014, no impairment charges were recorded.

Losses associated with the disposition or planned disposition of indefinite-lived intangible assets for the years ended December 31, 2016, December 31, 2015 and December 31, 2014 are discussed in Note 5.

The Company's intangible assets include both finite and indefinite-lived intangible assets. The Company's intangible assets with finite lives are amortized in accordance with the authoritative guidance for goodwill and other intangible assets, such as customer relationship assets, trade names, leasehold interests and non-compete agreements, primarily using the straight-line method over their estimated useful lives ranging from two to 20 years.

Amortization expense computed by the straight-line method totaled \$23.7 million for 2016, \$29.9 million for 2015 and \$21.7 million for 2014.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Goodwill and intangible assets (Continued)

The estimated annual amortization expense for the next five years for intangible assets at December 31, 2016 follows (in thousands):

2017	\$	17,391
2018	\$	14,870
2019	\$	14,355
2020	\$	14,205
2021	\$	14,088

A summary of intangible assets at December 31 follows (in thousands):

	2016				2015			
	Cost	Accumulated amortization	Carrying value	Weighted average life	Cost	Accumulated amortization	Carrying value	Weighted average life
Non-current:								
Certificates of need (indefinite life)	\$ 331,058	\$ -	\$331,058		\$ 289,421	\$ -	\$ 289,421	
Medicare certifications (indefinite life)	202,749	-	202,749		189,425	-	189,425	
Trade names (indefinite life)	118,569	-	118,569		119,569	-	119,569	
Non-compete agreements	2,335	(2,130)	205	2 years	4,466	(3,002)	1,464	3 years
Leasehold interests	16,015	(3,341)	12,674	8 years	10,520	(1,491)	9,029	9 years
Trade names	21,100	(16,163)	4,937	6 years	33,184	(21,435)	11,749	5 years
Customer relationship assets	200,989	(80,946)	120,043	14 years	203,291	(68,293)	134,998	14 years
	<u>\$ 892,815</u>	<u>\$ (102,580)</u>	<u>\$790,235</u>		<u>\$ 849,876</u>	<u>\$ (94,221)</u>	<u>\$ 755,655</u>	

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Insurance risks

Provisions for loss for professional liability risks and workers compensation risks are based upon management's best available information including actuarially determined estimates. The provisions for loss related to professional liability risks retained by the Company's wholly owned limited purpose insurance subsidiary are discounted based upon actuarial estimates of claim payment patterns and the risk-free interest rate for the respective policy year. Provisions for loss related to workers compensation risks retained by the Company's limited purpose insurance subsidiary are not discounted. To the extent that expected ultimate claims costs vary from historical provisions for loss, future earnings will be charged or credited. See Notes 6 and 11.

Earnings per common share

Earnings per common share are based upon the weighted average number of common shares outstanding during the respective periods. The diluted calculation of earnings per common share includes the dilutive effect of stock options, performance-based restricted shares and tangible equity units. The Company follows the provisions of the authoritative guidance for determining whether instruments granted in share-based payment transactions are participating securities for purposes of calculating earnings per common share. See Note 8.

Derivative financial instruments

The Company accounts for derivative financial instruments in accordance with the authoritative guidance for derivatives and hedging. These derivative financial instruments are recognized as liabilities in the accompanying consolidated balance sheet and are measured at fair value. The Company's derivatives are designated as cash flow hedges. The Company entered into interest rate swap agreements in January 2016 and March 2014 to hedge its floating interest rate risk.

The interest rate swaps were assessed for hedge effectiveness for accounting purposes and the Company determined the interest rate swaps qualify for cash flow hedge accounting at December 31, 2016. The Company records the effective portion of the gain or loss on the derivative financial instrument in accumulated other comprehensive income (loss) as a component of stockholders' equity and records the ineffective portion of the gain or loss on the derivative financial instrument as interest expense. See Note 14.

Variable interest entities

The Company follows the provisions of the authoritative guidance for determining whether an entity is a VIE. In order to determine if the Company is a primary beneficiary of a VIE for financial reporting purposes, it must consider whether it has the power to direct activities of the VIE that most significantly impact the performance of the VIE and whether the Company has the obligation to absorb losses or the right to receive returns that would be significant to the VIE. The Company consolidates a VIE when it is the primary beneficiary.

Of the Company's 19 operating IRFs, 17 are partnerships subject to an operating and management services agreement. Under GAAP, the Company determined that 14 of these 17 partnerships qualify as VIEs and concluded that the Company is the primary beneficiary in all but one partnership. The Company holds an ownership interest and acts as manager in each of the partnerships. Through the management services agreement, the Company is delegated necessary responsibilities to provide management services, administrative services and direction of the day-to-day operations. Based upon the Company's assessment of the most significant activities of the IRFs, the manager has the ability to direct the majority of those activities in 13 of these partnerships.

The analysis upon which the consolidation determination rests can be complex, can involve uncertainties, and requires judgment on various matters, some of which could be subject to different interpretations.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Variable interest entities (Continued)

The carrying amounts and classifications of the assets and liabilities of the consolidated VIEs are as follows (in thousands):

	December 31, 2016	December 31, 2015
Assets:		
Current assets:		
Cash and cash equivalents	\$ 41,681	\$ 36,798
Accounts receivable, net	33,996	36,085
Inventories	1,641	1,576
Other	2,824	3,001
	<u>80,142</u>	<u>77,460</u>
Property and equipment, net	16,736	17,100
Goodwill	275,375	271,717
Intangible assets, net	21,839	22,675
Other	15	54
Total assets	<u>\$ 394,107</u>	<u>\$ 389,006</u>
Liabilities:		
Current liabilities:		
Accounts payable	\$ 23,345	\$ 26,291
Salaries, wages and other compensation	3,160	3,261
Other accrued liabilities	3,046	2,784
Long-term debt due within one year	1,571	1,106
	<u>31,122</u>	<u>33,442</u>
Long-term debt	455	1,274
Deferred credits and other liabilities	7,357	4,971
Total liabilities	<u>\$ 38,934</u>	<u>\$ 39,687</u>

Stock option accounting

The Company recognizes compensation expense in its consolidated financial statements using a Black-Scholes option valuation model for non-vested stock options. See Note 17.

Other information

The Company has performed an evaluation of subsequent events through the date on which the financial statements were issued.

NOTE 2 – GENTIVA MERGER

On October 9, 2014, the Company entered into an Agreement and Plan of Merger with Gentiva, providing for the Company's acquisition of Gentiva. On February 2, 2015, the Company consummated the acquisition with one of its subsidiaries merging with and into Gentiva (the "Gentiva Merger"), with Gentiva continuing as the surviving company and the Company's wholly owned subsidiary.

At the effective time of the Gentiva Merger, each share of common stock, par value \$0.10 per share, of Gentiva ("Gentiva Common Stock") issued and outstanding immediately prior to the effective time of the Gentiva Merger (other than shares held by Kindred, Gentiva and any wholly owned subsidiaries (which were cancelled) and shares owned by stockholders who properly exercised and perfected a demand for appraisal rights under Delaware law), including each deferred share unit, were converted into the right to receive (i) \$14.50 in cash (the "Cash Consideration"), without interest, and (ii) 0.257 of a validly issued, fully paid and nonassessable share of Kindred common stock, par value \$0.25 per share ("Common Stock") (the "Stock Consideration"). The purchase price totaled \$722.3 million and was comprised of \$544.8 million of Cash Consideration and \$177.5 million of Stock Consideration. The Company also assumed \$1.2 billion of long-term debt, which was paid off upon consummation of the Gentiva Merger.

The Company used the net proceeds from the Gentiva Financing Transactions (as defined in Note 14), to fund the Cash Consideration for the Gentiva Merger, repay Gentiva's existing debt and pay related transaction fees and expenses.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 2 – GENTIVA MERGER (Continued)

Operating results for the year ended December 31, 2016 included transaction and integration costs totaling \$5.6 million, retention and severance totaling \$0.7 million, and a lease termination charge of \$0.3 million related to the Gentiva Merger. Operating results for the year ended December 31, 2015 included transaction and integration costs totaling \$37.9 million, retention and severance costs totaling \$60.3 million, a lease termination charge of \$0.8 million and financing costs totaling \$23.4 million related to the Gentiva Merger. Operating results for the year ended December 31, 2014 included transaction costs totaling \$10.8 million and financing costs totaling \$17.0 million. Transaction, integration, retention and severance costs were recorded as general and administrative expenses, and the lease termination charge was recorded as rent expense for 2016. Transaction, integration, retention and severance costs were recorded as general and administrative expenses, the lease termination charge was recorded as rent expense and financing costs were recorded as general and administrative expenses (\$6.0 million) and as interest expense (\$17.4 million) for 2015. Transaction costs were recorded as general and administrative expenses and financing costs were recorded as interest expense for 2014.

A note receivable totaling \$25 million was acquired in the Gentiva Merger. The note receivable was collected in full during the third quarter of 2015 and the Company received all of the cash proceeds.

Purchase price allocation

The Gentiva Merger purchase price of \$722.3 million was allocated based upon the estimated fair value of the tangible and intangible assets, and goodwill.

The following is the Gentiva Merger purchase price allocation (in thousands):

Cash and cash equivalents	\$ 64,695
Accounts receivable	265,034
Other current assets	123,428
Property and equipment	46,732
Identifiable intangible assets:	
Certificates of need (indefinite life)	256,921
Medicare certifications (indefinite life)	94,500
Trade names (indefinite life)	22,200
Trade name	15,600
Non-compete agreements	1,820
Leasehold interests	1,439
Total identifiable intangible assets	392,480
Deferred tax assets	37,429
Other assets	74,407
Current portion of long-term debt	(53,075)
Accounts payable and other current liabilities	(319,004)
Long-term debt, less current portion	(1,124,288)
Deferred tax liabilities	(47,748)
Other liabilities	(126,088)
Noncontrolling interests	(3,992)
Total identifiable net assets	(669,990)
Goodwill	1,392,271
Net assets	<u>\$ 722,281</u>

The fair value allocation was measured primarily using a discounted cash flows methodology, which is considered a Level 3 input (as described in Note 20).

The value of gross contractual accounts receivable before determining uncollectable amounts totaled \$278.9 million. Accounts estimated to be uncollectable totaled \$13.9 million.

The weighted average life of the definite lived intangible assets consisting primarily of a trade name is three years.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 2 – GENTIVA MERGER (Continued)

Purchase price allocation (Continued)

The aggregate goodwill arising from the Gentiva Merger is based upon the expected future cash flows of the Gentiva operations, which reflect both growth expectations and cost savings from combining the operations of the Company and Gentiva. Goodwill is not amortized and is not deductible for income tax purposes. Goodwill was assigned to the Company's home health reporting unit (\$612.2 million), hospice reporting unit (\$614.0 million) and community care reporting unit (\$166.1 million).

Pro forma information

The unaudited pro forma net effect of the Gentiva Merger assuming the acquisition occurred as of January 1, 2014 is as follows (in thousands, except per share amounts):

	Year ended December 31,	
	2015	2014
Revenues	\$ 7,216,606	\$ 7,020,543
Loss from continuing operations attributable to Kindred	(11,960)	(56,142)
Loss attributable to Kindred	(10,917)	(122,003)
Loss per common share:		
Basic:		
Loss from continuing operations	\$ (0.14)	\$ (0.66)
Net loss	\$ (0.13)	\$ (1.43)
Diluted:		
Loss from continuing operations	\$ (0.14)	\$ (0.66)
Net loss	\$ (0.13)	\$ (1.43)

The unaudited pro forma financial data have been derived by combining the historical financial results of the Company and the operations acquired in the Gentiva Merger for the periods presented. The unaudited pro forma financial data excludes transaction, integration, retention and severance costs, a lease termination charge, and financing costs totaling \$139.4 million incurred by both the Company and Gentiva in connection with the Gentiva Merger. These costs have been eliminated from the results of operations for 2015 and have been reflected as expenses incurred as of January 1, 2014 for purposes of the pro forma financial presentation. Revenues and earnings before interest, income taxes, transaction, integration, retention, and severance costs associated with Gentiva aggregated \$2.2 billion and \$309.6 million, respectively, for the year ended December 31, 2016 and \$1.9 billion and \$235.7 million, respectively, for 2015 since the date of the Gentiva Merger.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 3 – OTHER ACQUISITIONS

The following is a summary of the Company’s other acquisition activities. The operating results of the acquired businesses have been included in the accompanying consolidated financial statements of the Company from the respective acquisition dates. The purchase price of acquired businesses and acquired leased facilities resulted from negotiations with each of the sellers that were based upon both the historical and expected future cash flows of the respective businesses and real estate values. The majority of these acquisitions were financed through operating cash flows and borrowings under the Company’s ABL Facility (as defined in Note 14). Unaudited pro forma financial data related to the acquired businesses have not been presented because the acquisitions are not material, either individually or in the aggregate, to the Company’s consolidated financial statements.

<u>Acquisitions</u>	<u>Allocation of purchase price</u>						<u>Total purchase price, net of cash received</u>
	<u>Accounts receivable</u>	<u>Property and equipment</u>	<u>Goodwill</u>	<u>Identifiable intangible assets</u>	<u>Other assets</u>	<u>Deferred income taxes and other liabilities</u>	
Year ended December 31, 2016:							
Home health and hospice acquisitions (a)	\$ 989	\$ -	\$ 19,557	\$ 56,993	\$ -	\$ -	\$ 77,539
Acquisition of LTAC hospitals from Select	-	10,191	23,751	17,731	749	5,850	46,572
Home-based primary care acquisition	-	-	1,424	376	-	-	1,800
IRF acquisitions	-	-	2,800	1,129	-	2,800	1,129
Other	(3,287)	-	692	-	21	(2,574)	-
	<u>\$ (2,298)</u>	<u>\$ 10,191</u>	<u>\$ 48,224</u>	<u>\$ 76,229</u>	<u>\$ 770</u>	<u>\$ 6,076</u>	<u>\$ 127,040</u>
Year ended December 31, 2015:							
Acquisition of Centerre	\$ 28,525	\$ 15,122	\$ 265,737	\$ 23,512	\$ 21,135	\$ 174,766	\$ 179,265
Home-based primary care acquisitions	1,410	47	9,991	2,112	-	1,408	12,152
Home health acquisition	-	-	155	1,845	-	-	2,000
Other	-	-	5,980	-	-	5,980	-
	<u>\$ 29,935</u>	<u>\$ 15,169</u>	<u>\$ 281,863</u>	<u>\$ 27,469</u>	<u>\$ 21,135</u>	<u>\$ 182,154</u>	<u>\$ 193,417</u>
Year ended December 31, 2014:							
Home health and hospice acquisitions	\$ -	\$ -	\$ 983	\$ -	\$ -	\$ 833	\$ 150
Acquisition of previously leased real estate	-	22,871	-	2,590	(2,280)	(373)	23,554
Other	-	-	104	-	-	(328)	432
	<u>\$ -</u>	<u>\$ 22,871</u>	<u>\$ 1,087</u>	<u>\$ 2,590</u>	<u>\$ (2,280)</u>	<u>\$ 132</u>	<u>\$ 24,136</u>

(a) Outstanding accounts receivable owed to the Company totaling \$9.0 million was used as consideration for acquiring a hospice business.

The fair value of each of the acquisitions noted above was measured primarily using discounted cash flow methodologies which are considered Level 3 inputs (as described in Note 20).

For the three years ended December 31, 2016, the Company incurred \$8.7 million, \$109.1 million and \$18.0 million, respectively, in transaction costs. Transaction costs related to the Gentiva Merger incurred for the years ended December 31, 2016, 2015 and 2014 totaled \$6.3 million, \$104.2 million and \$10.8 million, respectively. These costs were charged to general and administrative expenses for the periods incurred.

In 2016, the Company acquired five long-term acute care (“LTAC”) hospitals (233 licensed beds) operated by Select Medical Holdings Corporation (“Select”) and sold three of its LTAC hospitals (255 licensed beds) to Select. The Company paid Select \$7.4 million, of which \$6.0 million was in lieu of selling another LTAC hospital to Select. See Note 5.

On January 1, 2015, the Company completed the acquisition of Centerre Healthcare Corporation (“Centerre”) for a purchase price of approximately \$195 million in cash. The Company paid approximately \$4 million in cash for a working capital settlement. Centerre operated 11 IRFs with 614 beds through partnerships.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 4 – IMPAIRMENT CHARGES

On October 1, 2016, the Company completed the sale of 12 LTAC hospitals (the “Hospitals”) to a group of entities operating under the name “Curahealth”, which are affiliates of a private investment fund sponsored by Nautic Partners, LLC (the “Curahealth Disposal”). In connection with (1) the Curahealth Disposal, (2) the closure of three LTAC hospitals in the third quarter of 2016, (3) a reduction in revenues associated with revenue rate reductions announced by the Center of Medicare and Medicaid Services (“CMS”) on August 2, 2016, (4) continued increases in labor costs during 2016, and (5) a refinement of the impact of LTAC patient criteria that became effective for the majority of the Company’s LTAC hospitals on September 1, 2016 (collectively, the “Hospital Division Triggering Event”), the Company was required to assess the recoverability of the hospital division reporting unit goodwill in the third quarter of 2016.

The goodwill impairment test involves a two-step process. The first step is a comparison of the reporting unit’s fair value to its carrying value. To determine the fair value of the hospital division reporting unit, the Company used a combination of an income approach and a market approach to calculate the fair value of the reporting unit. The discounted cash flow that served as the primary basis for the income approach was based upon the hospital division’s financial forecast of revenue, gross profit margins, operating costs and cash flows. As a result of the Hospital Division Triggering Event, the Company concluded that the carrying value of the hospital division reporting unit exceeded its estimated fair value. The second step of the test was then performed to measure the impairment loss, a process which compares the implied fair value of goodwill to the implied fair value for the reporting unit. The Company determined that a goodwill impairment charge aggregating \$261.1 million was necessary for the three months ended September 30, 2016. The Company also assessed the recoverability of the hospital division intangible assets and property and equipment and concluded a property and equipment impairment charge of \$3.2 million was necessary. The fair value of the assets was measured using Level 3 inputs such as operating cash flows, market data and replacement cost factoring in depreciation, economic obsolescence and inflation trends.

During the year ended December 31, 2016, the Hospitals met assets held for sale criteria as of September 30, 2016 and were subsequently sold to Curahealth on October 1, 2016. The Company recorded impairment charges in connection with the sale aggregating \$33.0 million, of which \$19.7 million was related to property and equipment, and \$13.3 million was related to goodwill and other intangible assets. These charges reflect the amounts by which the carrying value of the assets exceeded their estimated fair value. The fair value of the assets was measured using a Level 3 input of the offer pending from Curahealth at September 30, 2016. In addition, in the first quarter of 2016, the Company also recorded a property and equipment impairment charge of \$7.8 million under the held and used accounting model related to the planned Curahealth Disposal. The fair value of property and equipment in the first quarter of 2016 was measured using Level 3 inputs, primarily replacement costs.

During 2016, the nursing center division experienced a decline in financial performance as compared to projected results and in the third quarter of 2016, the Company determined it was more likely than not that it would dispose of its skilled nursing facility business. As a result, the Company tested the recoverability of its nursing center division intangible assets and property and equipment under the held and used accounting model. No goodwill exists on the nursing centers reporting unit’s balance sheet. The Company determined that a property and equipment impairment charge aggregating \$22.5 million was necessary for the year ended December 31, 2016. The fair value of the assets was measured using Level 3 inputs, such as operating cash flows and replacement costs.

During the year ended December 31, 2016, the Company reviewed the long-lived assets related to the planned divestiture and pending offers for a nursing center held for sale and determined its property and equipment was impaired. As a result, the Company recorded an impairment charge of \$5.3 million. The fair value of the assets was measured based upon pending offers, a Level 3 input.

During the year ended December 31, 2016, the Company recorded an asset impairment charge of \$2.6 million related to the sale of a hospital division medical office building. This charge reflects the amount by which the carrying value of the property exceeded its estimated fair value. The fair value of the property was measured using a Level 3 input of the offer pending at June 30, 2016. The property was subsequently sold during the third quarter of 2016.

The Company determined that the sale of three LTAC hospitals to Select during the second quarter of 2016 was an impairment triggering event in the hospital reporting unit. The Company tested the recoverability of the hospital reporting unit goodwill and determined that goodwill was not impaired.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 4 – IMPAIRMENT CHARGES (Continued)

The annual impairment tests for certain of the Company's indefinite-lived intangible assets are performed as of May 1 and October 1. As part of the annual indefinite-lived impairment review at October 1, 2016, an impairment charge of \$3.6 million was recorded related to previously acquired home health and hospice Medicare certifications, certificates of need and a trade name. These charges reflect the amount by which the carrying value exceeded its estimated fair value. The fair values of the assets were measured using Level 3 inputs, such as projected revenues and operating cash flows. As part of the impairment review at May 1, 2016, an impairment charge of \$3.5 million was recorded related to certificates of need for two hospitals. This charge reflects the amount by which the carrying value of the certificates of need exceeded its estimated fair value. The fair value of the certificates of need was measured using Level 3 inputs, such as operating cash flows.

In connection with the preparation of the Company's operating results for the third quarter of 2015, the Company determined that the impact of the regulatory changes announced on July 31, 2015 as part of the Pathway for SGR Reform Act of 2013 (the "SGR Reform Act") related to the Company's hospital reporting unit was an impairment triggering event. As part of the SGR Reform Act, Congress adopted various legislative changes impacting LTAC hospitals (the "LTAC Legislation"). The LTAC Legislation created new Medicare patient criteria and payment rules for LTAC hospitals. The Company tested the recoverability of its hospital reporting unit goodwill and determined that goodwill was not impaired.

During the fourth quarter of 2015, the Company recorded an asset impairment charge of \$18.0 million related to the previously acquired RehabCare trade name due to the cancellation of contracts associated with one large customer in the fourth quarter of 2015 and a reduction in projected revenues in 2016. The fair value of the trade name was measured using Level 3 inputs such as projected revenues and the industry specific royalty rate.

During the year ended December 31, 2015, the Company recorded an asset impairment charge of \$6.7 million related to previously acquired home health and hospice trade names after the decision in the first quarter of 2015 to rebrand to the Kindred at Home trade name. These charges reflect the amount by which the carrying value exceeded its estimated fair value. The fair value of the trade names was measured using Level 3 unobservable inputs, primarily economic obsolescence.

All of the previously mentioned charges were recorded as impairment charges in the accompanying consolidated statement of operations for all periods. None of the impairment charges impacted the Company's cash flows or liquidity.

NOTE 5 – DIVESTITURES

Continuing operations

During 2016, the Company closed three LTAC hospitals, one nursing center and seven home health and hospice locations and recorded write-offs of property and equipment of \$8.5 million, indefinite-lived intangible assets of \$8.7 million and leasehold liabilities of \$5.2 million.

During 2015, the Company either sold or closed 22 home health and hospice locations and recorded write-offs of property and equipment of \$1.4 million, indefinite-lived intangible assets of \$8.9 million and goodwill of \$2.6 million, which was based upon the relative fair value of the sold home health and hospice locations.

All of the previously mentioned charges were recorded as restructuring charges in the accompanying consolidated statement of operations for all periods.

During 2016, the Company also completed the Curahealth Disposal for \$21.0 million in net cash proceeds, the facility swap with Select and sold a hospital division medical office building for \$3.7 million. See Notes 3 and 4.

Discontinued operations

In accordance with the authoritative guidance for the impairment or disposal of long-lived assets, the divestitures or planned divestiture of unprofitable businesses discussed in Note 1 has been accounted for as discontinued operations. Accordingly, the results of operations of these businesses for all periods presented and the gains, losses or impairments associated with these transactions have been classified as discontinued operations, net of income taxes, in the accompanying consolidated statement of operations based upon the authoritative guidance which was in effect through December 31, 2014. Effective January 1, 2015, the authoritative guidance modified the requirements for reporting discontinued operations. A disposal is now required to be reported in discontinued operations only if the disposal represents a strategic shift that has (or will have) a major effect on the Company's operations and financial results. At December 31, 2016, the Company has sold all facilities previously held for sale as discontinued operations.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 5 – DIVESTITURES (Continued)

Discontinued operations (Continued)

On December 27, 2014, the Company entered into an agreement with Ventas, Inc. (“Ventas”) to transition the operations under the leases for nine non-strategic nursing centers (the “2014 Expiring Facilities”). Each lease terminated when the operation of such nursing center was transferred to a new operator. During 2015, the Company transferred the operations of seven of the 2014 Expiring Facilities and recorded a gain on divestiture of \$2.0 million (\$1.2 million net of income taxes). The two remaining facilities were transferred during 2016 and the Company recorded a gain on divestiture of \$0.3 million (\$0.3 million net of income taxes). The lease term for eight of these nursing centers was scheduled to expire on April 30, 2018. The lease term for the ninth of these nursing centers was scheduled to expire on April 30, 2020. For accounting purposes, the 2014 Expiring Facilities qualified as assets held for sale. Under the terms of the agreement to transition operations of the 2014 Expiring Facilities, the Company incurred a \$40 million termination fee in exchange for the early termination of the leases, which was paid to Ventas in January 2015. The early termination fee was accrued as rent expense in discontinued operations in 2014.

The 2014 Expiring Facilities contained 903 licensed nursing center beds and generated revenues of approximately \$62 million for the year ended December 31, 2014. The annual rent for these facilities approximated \$10 million.

During 2014, the Company either closed, divested or terminated the lease for operations of three TC hospitals and two nursing centers. The Company recorded a net loss on divestiture of \$0.7 million (\$0.4 million net of income taxes) for the year ended December 31, 2014 related to these divestitures.

The Company allowed the lease to expire on a TC hospital during 2014 resulting in a loss on divestiture primarily related to a write-off of an indefinite-lived intangible asset of \$3.4 million (\$2.1 million net of income taxes) for the year ended December 31, 2014.

On September 30, 2013, the Company entered into agreements with Ventas to exit 59 nursing centers and close another facility (collectively, the “2013 Expiring Facilities”). The Company transferred the operations of all of the 2013 Expiring Facilities to new operators during the year ended December 31, 2014. Another facility was closed and its operating license and equipment were sold during the year ended December 31, 2014. Proceeds from the sale of equipment and inventory for the 2013 Expiring Facilities totaled \$15.0 million for the year ended December 31, 2014.

The Company recorded a loss on divestiture of \$10.0 million (\$6.3 million net of income taxes) for the year ended December 31, 2014, related to the sale of 15 non-strategic hospitals and one nursing center to an affiliate of Vibra Healthcare, LLC. The loss on divestiture related to an allowance for the settlement of disposed working capital under the terms of the sale agreement.

The results of operations and the gains or losses on divestiture of operations, net of income taxes, for the above dispositions were reclassified to discontinued operations in the accompanying consolidated statement of operations for all historical periods.

NOTE 6 – DISCONTINUED OPERATIONS

In accordance with the authoritative guidance for the impairment or disposal of long-lived assets, the divestiture of certain unprofitable businesses discussed in Notes 1 and 5 have been accounted for as discontinued operations. Accordingly, the results of operations of these businesses for all periods presented and the gains, losses or impairments related to these divestitures have been classified as discontinued operations, net of income taxes, in the accompanying consolidated statement of operations. At December 31, 2016, the Company has sold all facilities previously held for sale.

Discontinued operations included favorable pretax adjustments of \$4.0 million (\$2.4 million net of income taxes) in 2016 and \$4.9 million (\$3.0 million net of income taxes) in 2015 and an unfavorable pretax adjustment of \$2.5 million (\$1.5 million net of income taxes) in 2014 resulting from changes in estimates for professional liability reserves related to prior years.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 6 – DISCONTINUED OPERATIONS (Continued)

A summary of discontinued operations follows (in thousands):

	Year ended December 31,		
	2016	2015	2014
Revenues	\$ 7,235	\$ 43,145	\$ 297,099
Salaries, wages and benefits	1,813	20,821	126,370
Supplies	134	2,265	15,528
Rent	2,157	7,368	83,107
Other operating expenses	564	8,030	57,246
General and administrative expenses (income)	(4,300)	3,936	94,062
Impairment charges	-	-	673
Depreciation	237	1,123	5,380
Interest expense	17	4	18
Investment income	(3)	(14)	(478)
	<u>619</u>	<u>43,533</u>	<u>381,906</u>
Income (loss) from operations before income taxes	6,616	(388)	(84,807)
Income tax benefit	-	(153)	(31,177)
Income (loss) from operations	6,616	(235)	(53,630)
Gain (loss) on divestiture of operations	295	1,244	(12,698)
Income (loss) from discontinued operations	6,911	1,009	(66,328)
(Earnings) loss attributable to noncontrolling interests	(4)	34	467
Income (loss) attributable to Kindred	<u>\$ 6,907</u>	<u>\$ 1,043</u>	<u>\$ (65,861)</u>

The following table sets forth certain discontinued operations data by business segment (in thousands):

	Year ended December 31,		
	2016	2015	2014
Revenues:			
Hospital division	\$ 2,704	\$ 2,368	\$ 26,571
Nursing center division	4,531	40,777	270,528
	<u>\$ 7,235</u>	<u>\$ 43,145</u>	<u>\$ 297,099</u>
Segment EBITDAR:			
Hospital division	\$ 2,146	\$ 920	\$ (3,798)
Nursing center division	6,878	7,173	7,018
	<u>\$ 9,024</u>	<u>\$ 8,093</u>	<u>\$ 3,220</u>
Rent:			
Hospital division	\$ 1,863	\$ 1,989	\$ 4,174
Nursing center division	294	5,379	78,933
	<u>\$ 2,157</u>	<u>\$ 7,368</u>	<u>\$ 83,107</u>
Depreciation:			
Hospital division	\$ -	\$ -	\$ 1,700
Nursing center division	237	1,123	3,680
	<u>\$ 237</u>	<u>\$ 1,123</u>	<u>\$ 5,380</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 6 – DISCONTINUED OPERATIONS (Continued)

A summary of the net assets held for sale follows (in thousands):

	December 31, 2016	December 31, 2015
Long-term assets:		
Property and equipment, net	\$ -	\$ 571
Other	-	42
	-	613
Current liabilities	-	-
	\$ -	\$ 613

NOTE 7 – RESTRUCTURING CHARGES

The Company has initiated various restructuring activities whereby it has incurred costs associated with reorganizing its operations, including the divestiture, swap, closure and consolidation of facilities and branches, reduced headcount and realigned operations in order to improve cost efficiencies in response to changes in the healthcare industry and to partially mitigate reductions in reimbursement rates from third party payors. The costs associated with these activities are reported as restructuring charges in the statement of operations and would have been recorded as general and administrative expense or rent expense if not classified as restructuring charges.

The following table sets forth the restructuring charges incurred by business segment (in thousands):

	Year ended December 31,		
	2016	2015	2014
Kindred at Home:			
Home health	\$ 4,947	\$ 7,335	\$ -
Hospice	2,822	4,386	-
	7,769	11,721	-
Hospital division	81,779	897	-
Kindred Rehabilitation Services:			
Kindred Hospital Rehabilitation Services	128	-	-
RehabCare	586	-	-
	714	-	-
Nursing center division	11,049	352	4,435
Support center	5,864	-	-
	\$ 107,175	\$ 12,970	\$ 4,435

Restructuring Activities

Skilled Nursing Facility Business Exit

During the fourth quarter of 2016, the Company approved the strategic plan to exit the skilled nursing facility business as an owner and operator. As a result, the Company plans to optimize its overhead structure by eliminating divisional and corporate overhead above the facility level. The activities related to the skilled nursing facility business exit plan are expected to include retention, lease terminations costs, facility closure and other costs, and professional fees, which are expected to be substantially complete in 2018.

The composition of the restructuring charges that the Company has incurred for these activities is as follows (in thousands):

	Year ended December 31,		
	2016	2015	2014
Retention	\$ 4,042	\$ -	\$ -
Professional and other costs	2,997	-	-
	\$ 7,039	\$ -	\$ -

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 7 – RESTRUCTURING CHARGES (Continued)

Restructuring Activities (Continued)

Skilled Nursing Facility Business Exit (Continued)

The following table summarizes the Company's skilled nursing facility business exit plan restructuring liability activity (included in current liabilities) (in thousands):

	Professional and other costs	Retention costs	Total
Liability balance at January 1, 2015	\$ -	\$ -	\$ -
Expense	-	-	-
Payments	-	-	-
Liability balance at December 31, 2015	-	-	-
Expense	2,997	4,042	7,039
Payments	(2,577)	(122)	(2,699)
Liability balance at December 31, 2016	<u>\$ 420</u>	<u>\$ 3,920</u>	<u>\$ 4,340</u>

LTAC Portfolio Repositioning

During the first quarter of 2016, the Company approved an LTAC portfolio repositioning plan that incorporated the divestiture, swap or closure of certain LTAC hospitals as part of its mitigation strategies to prepare for new patient criteria for LTAC hospitals under the LTAC Legislation. The activities related to the LTAC portfolio repositioning plan were substantially completed during 2016.

During the year ended December 31, 2016, the Company completed the facility swap with Select and the Curahealth Disposal. See Notes 4 and 5. In addition, the Company closed three LTAC hospitals in the third quarter of 2016 and had similar hospital division realignment initiatives during 2015.

The composition of the restructuring charges that the Company has incurred for these activities is as follows (in thousands):

	Year ended December 31,		
	2016	2015	2014
Lease termination costs	\$ 57,833	\$ 207	\$ -
Facility closure, loss on disposal and other costs	20,719	167	-
Severance	3,227	523	-
Transaction costs	2,414	-	-
	<u>\$ 84,193</u>	<u>\$ 897</u>	<u>\$ -</u>

The following table (in thousands) summarizes the Company's LTAC portfolio repositioning liability activity (included in current liabilities and other long-term liabilities), which includes the Ventas lease termination fee discounted at the Company's credit-adjusted risk-free rate. Non-cash charges of \$15.4 million related to facility closure, lease termination, loss on disposal and other costs are excluded. See Note 13.

	Lease termination costs	Severance and transaction costs	Total
Liability balance at January 1, 2015	\$ -	\$ -	\$ -
Expense	207	523	730
Payments	(207)	(523)	(730)
Liability balance at December 31, 2015	-	-	-
Expense	63,154	5,641	68,795
Payments	(9,728)	(5,626)	(15,354)
Liability balance at December 31, 2016	<u>\$ 53,426</u>	<u>\$ 15</u>	<u>\$ 53,441</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 7 – RESTRUCTURING CHARGES (Continued)

Restructuring Activities (Continued)

Kindred at Home Branch Consolidations

During the first quarter of 2015, the Company approved and initiated branch consolidations in specific markets to improve operations and cost efficiencies in the Kindred at Home division. The branch consolidations included branches that served both the home health and hospice business segment operations. Gentiva initiated similar branch consolidations prior to the Gentiva Merger and these activities and acquired liabilities are included herein. These activities were substantially completed during 2016.

The composition of the restructuring costs that the Company has incurred for these consolidations is as follows (in thousands):

	Year ended December 31,		
	2016	2015	2014
Lease termination costs	\$ 3,559	\$ 2,161	\$ -
Branch closure and other costs	2,820	9,560	-
Severance	1,390	-	-
	<u>\$ 7,769</u>	<u>\$ 11,721</u>	<u>\$ -</u>

The following table summarizes the Company's Kindred at Home branch consolidation restructuring liability activity (included in current liabilities) (in thousands):

	Lease termination costs
Liability balance at January 1, 2015	\$ -
Liability acquired in Gentiva Merger	4,011
Expense	2,161
Payments	(3,805)
Other	(504)
Liability balance at December 31, 2015	1,863
Expense	3,559
Payments	(2,427)
Other	65
Liability balance at December 31, 2016	<u>\$ 3,060</u>

2016 Division and Support Center Reorganizations

During the year ended December 31, 2016, the Company initiated a restructuring plan to improve operations and cost efficiencies in the nursing center division and the Kindred Rehabilitation Services division. In addition, during the fourth quarter of 2016, the Company initiated a similar restructuring plan to realign costs in its support center. Actions related to these plans were completed during 2016.

The composition of the restructuring costs that the Company has incurred for these division reorganizations is as follows (in thousands):

	Year ended December 31,		
	2016	2015	2014
Severance	\$ 5,734	\$ -	\$ -
Asset write-offs	2,440	-	-
Lease termination cost	-	352	-
	<u>\$ 8,174</u>	<u>\$ 352</u>	<u>\$ -</u>

2014 Nursing Center Division Reorganization

During the second quarter of 2014, the Company initiated a restructuring plan to streamline the nursing center division's divisional and regional support structure following 2014 facility divestitures. As a result, the Company reorganized the division by eliminating the regional structure and creating ten districts throughout the country. The activities related to the 2014 nursing center division reorganization include severance, lease terminations costs and asset write-offs, which were completed as of December 31, 2014.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 7 – RESTRUCTURING CHARGES (Continued)

Restructuring Activities (Continued)

2014 Nursing Center Division Reorganization (Continued)

The composition of the restructuring charges that the Company has incurred for these activities is as follows (in thousands):

	Year ended December 31,		
	2016	2015	2014
Severance	\$ -	\$ -	\$ 3,994
Lease termination costs	-	-	247
Asset write-offs	-	-	194
	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 4,435</u>

NOTE 8 – LOSS PER SHARE

Loss per common share is based upon the weighted average number of common shares outstanding during the respective periods. Because the Company is reporting a loss from continuing operations attributable to the Company for the three years ended December 31, 2016, the diluted calculation of earnings per common share excludes the dilutive impact of stock options, performance-based restricted shares and tangible equity units of 1.7 million, 2.6 million and 1.3 million for the years 2016, 2015 and 2014, respectively. The Company follows the provisions of the authoritative guidance for determining whether instruments granted in share-based payment transactions are participating securities, which requires that unvested restricted stock that entitles the holder to receive nonforfeitable dividends before vesting be included as a participating security in the basic and diluted earnings per common share calculation pursuant to the two-class method. However, because the Company reported a loss from continuing operations attributable to the Company, there was no allocation to participating unvested restricted stockholders for all periods presented.

NOTE 9 – BUSINESS SEGMENT DATA

The Company was organized into four operating divisions: the Kindred at Home division, the hospital division, the Kindred Rehabilitation Services division, and the nursing center division. Based upon the authoritative guidance for business segments, the operating divisions represent six reportable operating segments, including (1) home health services, (2) hospice services, (3) hospitals, (4) Kindred Hospital Rehabilitation Services, (5) RehabCare, and (6) nursing centers. These reportable operating segments are consistent with information used by the Company's President and Chief Executive Officer and its Chief Operating Officer to assess performance and allocate resources. The accounting policies of the operating segments are the same as those described in the summary of significant accounting policies.

For segment purposes, the Company defines segment EBITDAR as earnings before interest, income taxes, depreciation, amortization, and rent. Segment EBITDAR reported for each of the Company's operating segments excludes litigation contingency expense, impairment charges, restructuring charges, transaction costs, and the allocation of support center overhead.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 9 – BUSINESS SEGMENT DATA (Continued)

The following table sets forth certain data by business segment (in thousands):

	Year ended December 31,		
	2016	2015	2014
Revenues:			
Kindred at Home:			
Home health	\$ 1,762,622	\$ 1,578,500	\$ 298,907
Hospice	736,803	656,527	50,095
	<u>2,499,425</u>	<u>2,235,027</u>	<u>349,002</u>
Hospital division	2,383,063	2,440,779	2,450,068
Kindred Rehabilitation Services:			
Kindred Hospital Rehabilitation Services	674,648	609,122	374,201
RehabCare	784,292	915,486	1,007,036
	<u>1,458,940</u>	<u>1,524,608</u>	<u>1,381,237</u>
Nursing center division	1,087,936	1,092,075	1,062,549
	<u>7,429,364</u>	<u>7,292,489</u>	<u>5,242,856</u>
Eliminations:			
Kindred Hospital Rehabilitation Services	(89,724)	(91,301)	(91,232)
RehabCare	(113,135)	(140,540)	(120,808)
Nursing centers	(6,986)	(5,741)	(3,217)
	<u>(209,845)</u>	<u>(237,582)</u>	<u>(215,257)</u>
	<u>\$ 7,219,519</u>	<u>\$ 7,054,907</u>	<u>\$ 5,027,599</u>
Income (loss) from continuing operations:			
Segment EBITDAR:			
Kindred at Home:			
Home health	\$ 279,531	\$ 256,173	\$ 20,149
Hospice	116,326	109,120	5,390
	<u>395,857</u>	<u>365,293</u>	<u>25,539</u>
Hospital division	436,071	478,205	522,955
Kindred Rehabilitation Services:			
Kindred Hospital Rehabilitation Services	197,123	176,127	98,196
RehabCare	40,082	43,815	70,974
	<u>237,205</u>	<u>219,942</u>	<u>169,170</u>
Nursing center division	127,342	149,364	150,916
Support center	(257,006)	(255,229)	(203,075)
Litigation contingency expense	(2,840)	(138,648)	(4,600)
Impairment charges	(342,559)	(24,757)	-
Restructuring charges	(45,783)	(10,250)	(4,188)
Transaction costs	(8,679)	(109,131)	(17,983)
EBITDAR	<u>539,608</u>	<u>674,789</u>	<u>638,734</u>
Rent	(390,534)	(379,889)	(312,792)
Restructuring charges - rent	(61,392)	(2,720)	(247)
Depreciation and amortization	(159,402)	(157,251)	(155,570)
Interest, net	<u>(231,485)</u>	<u>(229,589)</u>	<u>(164,767)</u>
Income (loss) from continuing operations before income taxes	(303,205)	(94,660)	5,358
Provision (benefit) for income taxes	314,330	(42,797)	462
	<u>\$ (617,535)</u>	<u>\$ (51,863)</u>	<u>\$ 4,896</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 9 – BUSINESS SEGMENT DATA (Continued)

	Year ended December 31,		
	2016	2015	2014
Rent:			
Kindred at Home:			
Home health	\$ 34,328	\$ 32,922	\$ 7,832
Hospice	17,439	16,639	950
	<u>51,767</u>	<u>49,561</u>	<u>8,782</u>
Hospital division	207,063	206,485	205,163
Kindred Rehabilitation Services:			
Kindred Hospital Rehabilitation Services	35,277	30,780	7,041
RehabCare	3,637	3,825	4,199
	<u>38,914</u>	<u>34,605</u>	<u>11,240</u>
Nursing center division	90,856	85,885	85,322
Support center	1,934	3,353	2,285
	<u>\$ 390,534</u>	<u>\$ 379,889</u>	<u>\$ 312,792</u>
Depreciation and amortization:			
Kindred at Home:			
Home health	\$ 15,721	\$ 17,279	\$ 7,622
Hospice	6,364	6,581	645
	<u>22,085</u>	<u>23,860</u>	<u>8,267</u>
Hospital division	50,014	53,975	65,681
Kindred Rehabilitation Services:			
Kindred Hospital Rehabilitation Services	14,527	13,511	11,827
RehabCare	7,961	7,780	11,129
	<u>22,488</u>	<u>21,291</u>	<u>22,956</u>
Nursing center division	28,198	28,091	30,103
Support center	36,617	30,034	28,563
	<u>\$ 159,402</u>	<u>\$ 157,251</u>	<u>\$ 155,570</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 9 – BUSINESS SEGMENT DATA (Continued)

	Year ended December 31,		
	2016	2015	2014
Capital expenditures, excluding acquisitions (including discontinued operations):			
Kindred at Home:			
Home health:			
Routine	\$ 6,401	\$ 4,201	\$ 783
Development	-	-	-
	<u>6,401</u>	<u>4,201</u>	<u>783</u>
Hospice:			
Routine	2,342	1,215	64
Development	-	-	-
	<u>2,342</u>	<u>1,215</u>	<u>64</u>
Hospital division:			
Routine	23,858	28,935	29,881
Development	-	-	2,087
	<u>23,858</u>	<u>28,935</u>	<u>31,968</u>
Kindred Rehabilitation Services:			
Kindred Hospital Rehabilitation Services:			
Routine	1,389	948	194
Development	20,773	4,701	-
	<u>22,162</u>	<u>5,649</u>	<u>194</u>
RehabCare:			
Routine	1,867	1,449	2,247
Development	-	-	-
	<u>1,867</u>	<u>1,449</u>	<u>2,247</u>
Nursing center division:			
Routine	17,377	18,781	20,976
Development	5,935	11,746	3,170
	<u>23,312</u>	<u>30,527</u>	<u>24,146</u>
Support center:			
Routine:			
Information systems	38,123	64,813	35,896
Other	4,695	1,589	1,040
Development	8,117	3,484	-
	<u>50,935</u>	<u>69,886</u>	<u>36,936</u>
Totals:			
Routine	96,052	121,931	91,081
Development	34,825	19,931	5,257
	<u>\$ 130,877</u>	<u>\$ 141,862</u>	<u>\$ 96,338</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 9 – BUSINESS SEGMENT DATA (Continued)

	December 31, 2016	December 31, 2015
Assets at end of period:		
Kindred at Home:		
Home health	\$ 1,540,370	\$ 1,435,176
Hospice	929,774	922,710
	<u>2,470,144</u>	<u>2,357,886</u>
Hospital division	1,211,305	1,633,801
Kindred Rehabilitation Services:		
Kindred Hospital Rehabilitation Services	814,838	802,686
RehabCare	329,516	347,738
	<u>1,144,354</u>	<u>1,150,424</u>
Nursing center division	491,506	494,066
Support center	795,415	832,082
	<u>\$ 6,112,724</u>	<u>\$ 6,468,259</u>
Goodwill:		
Kindred at Home:		
Home health	\$ 919,482	\$ 905,989
Hospice	646,329	639,006
	<u>1,565,811</u>	<u>1,544,995</u>
Hospital division	361,310	628,519
Kindred Rehabilitation Services:		
Kindred Hospital Rehabilitation Services	499,953	496,296
RehabCare	-	-
	<u>499,953</u>	<u>496,296</u>
	<u>\$ 2,427,074</u>	<u>\$ 2,669,810</u>

NOTE 10 – INCOME TAXES

At each balance sheet date, management assesses all available positive and negative evidence to determine whether a valuation allowance is needed against its deferred tax assets. The authoritative guidance requires evidence related to events that have actually happened to be weighted more significantly than evidence that is projected or expected to happen. A significant piece of negative evidence according to this weighting standard is if there are cumulative losses in the two most recent years and the current year, which was the case for the Company at December 31, 2016. The Company's outlook of taxable income for 2016 changed after the Company recorded \$286.8 million of goodwill and property and equipment impairment charges associated with (1) the Hospital Division Triggering Event and (2) the decline in nursing center division financial performance in 2016 combined with the planned disposal of the Company's skilled nursing facility business. In addition, the divestiture of the skilled nursing facility business may generate additional taxable losses in the future related to the transaction.

In addition, the Company has deferred tax liabilities related to tax amortization of acquired indefinite lived intangible assets because these assets are not amortized for financial reporting purposes. The tax amortization in current and future years created a deferred tax liability which will reverse at the time of ultimate sale or book impairment. Due to the uncertain timing of this reversal, the temporary difference associated with indefinite lived intangible assets cannot be considered a source of future taxable income for purposes of determining the valuation allowance. As such, this deferred tax liability cannot be used to offset the deferred tax asset related to the net deferred tax assets.

On the basis of this evaluation, as of December 31, 2016, the Company recorded a valuation allowance of \$385.8 million (including discontinued operations) against the Company's deferred tax assets. As of December 31, 2016, the Company has a net deferred tax liability of \$201.8 million representing indefinite lived intangible assets. The amount of deferred tax asset considered realizable, however, could be adjusted if the weighting of the positive and negative evidence changes.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 10 – INCOME TAXES (Continued)

Provision (benefit) for income taxes consists of the following (in thousands):

	Year ended December 31,		
	2016	2015	2014
Current:			
Federal	\$ -	\$ -	\$ -
State	3,992	3,683	4,901
	3,992	3,683	4,901
Deferred	310,338	(46,480)	(4,439)
	<u>\$ 314,330</u>	<u>\$ (42,797)</u>	<u>\$ 462</u>

Reconciliation of federal statutory tax expense (income) to the provision (benefit) for income taxes follows (in thousands):

	Year ended December 31,		
	2016	2015	2014
Income tax expense (income) at federal rate	\$ (106,122)	\$ (33,131)	\$ 1,875
State income tax expense (income), net of federal income tax expense (income)	(13,077)	(2,726)	1,581
Transaction costs	-	4,832	3,163
Impairment charges	66,357	890	-
Valuation allowance	388,472	-	-
Prior year contingencies	(207)	426	(230)
Noncontrolling interests	(21,403)	(16,926)	(7,348)
Compensation related charges	1,204	3,055	1,992
Federal and state tax credits	(1,698)	(3,033)	(1,820)
Other items, net	804	3,816	1,249
	<u>\$ 314,330</u>	<u>\$ (42,797)</u>	<u>\$ 462</u>

Other items consist of meals, entertainment, lobbying, and other permanent differences, which individually are deemed immaterial.

A summary of net deferred income tax assets (liabilities) by source included in the accompanying consolidated balance sheet at December 31 follows (in thousands):

	2016		2015	
	Assets	Liabilities	Assets	Liabilities
Property and equipment	\$ -	\$ 18,457	\$ -	\$ 24,968
Insurance	50,901	-	48,430	-
Account receivable allowances	39,739	-	34,029	-
Compensation	56,746	-	75,277	-
Net operating losses	222,828	-	179,074	-
Assets held for sale	-	-	-	189
Litigation	-	-	47,078	-
Goodwill and intangibles	-	226,490	-	265,608
Lease amendments	17,426	-	-	-
Jobs tax and other credits	28,310	-	23,415	-
Other	50,343	-	34,268	-
	466,293	<u>\$ 244,947</u>	441,571	<u>\$ 290,765</u>
Reclassification of deferred tax liabilities	(244,947)	-	(290,765)	-
Net deferred tax assets	221,346	-	150,806	-
Valuation allowance	(423,154)	-	(46,676)	-
	<u>\$ (201,808)</u>	-	<u>\$ 104,130</u>	-

Net deferred income taxes totaling \$201.8 million and \$104.1 million at December 31, 2016 and 2015, respectively, were classified as noncurrent liabilities and noncurrent assets, respectively.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 10 – INCOME TAXES (Continued)

The Company identified deferred tax assets for federal income tax net operating losses (“NOLs”) of \$162.4 million with a corresponding deferred income tax valuation allowance of \$162.4 million at December 31, 2016. The Company had deferred income tax assets for federal income tax NOLs of \$119.1 million at December 31, 2015 with no corresponding deferred income tax valuation allowance. The federal income tax NOLs expire in various amounts through 2036. The Company had deferred income tax assets for state income tax NOLs of \$60.4 million and \$60.0 million at December 31, 2016 and December 31, 2015, respectively, and a corresponding deferred income tax valuation allowance of \$60.0 million and \$46.7 million at December 31, 2016 and December 31, 2015, respectively, for that portion of the net deferred income tax assets that the Company will likely not realize in the future.

The Company follows the provisions of the authoritative guidance for accounting for uncertainty in income taxes which clarifies the accounting for uncertain income tax issues recognized in an entity’s financial statements. The guidance prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in an income tax return.

A reconciliation of unrecognized tax benefits follows (in thousands):

Balance, December 31, 2013	\$ 298
Reductions due to lapses of applicable statute of limitations and the conclusion of income tax examinations	(298)
Balance, December 31, 2014	-
Acquisition	6,814
Balance, December 31, 2015	6,814
Reductions due to the conclusion of income tax examinations	(1,001)
Balance, December 31, 2016	<u>\$ 5,813</u>

The Company records accrued interest and penalties associated with uncertain tax positions as income tax expense in the consolidated statement of operations. Accrued interest related to uncertain tax provisions totaled \$3.3 million as of December 31, 2016 and \$2.7 million as of December 31, 2015.

The federal statute of limitations remains open for tax years 2013 through 2015. During 2016, the Company resolved federal income tax audits for the 2014 tax year. During 2015, Gentiva and its subsidiaries also resolved federal tax audits for the 2014 tax year under the Internal Revenue Service (the “IRS”) Compliance Assurance Process (“CAP”) program. The Company is currently under examination by the IRS for the 2015 and 2016 tax years. The Company has been accepted into the CAP program for the 2015 through 2017 tax years. The CAP program is an enhanced, real-time review of a company’s tax positions and compliance. The Company expects participation in the CAP program will improve the timeliness of its federal tax examinations.

State jurisdictions generally have statutes of limitations for tax returns ranging from three to five years. The state impact of federal income tax changes remains subject to examination by various states for a period of up to one year after formal notification to the states. Currently, the Company has various state income tax returns under examination.

NOTE 11 – INSURANCE RISKS

The Company insures a substantial portion of its professional liability risks and workers compensation risks through its limited purpose insurance subsidiary. Provisions for loss for these risks are based upon management’s best available information including actuarially determined estimates. Effective with the Gentiva Merger, the Company cancelled all policies issued by the Gentiva wholly owned limited purpose insurance subsidiary and insures all post-merger risks through the Company’s insurance subsidiary.

The allowance for professional liability risks includes an estimate of the expected cost to settle reported claims and an amount, based upon past experiences, for losses incurred but not reported. These liabilities are necessarily based upon estimates and, while management believes that the provision for loss is adequate, the ultimate liability may be in excess of, or less than, the amounts recorded. To the extent that expected ultimate claims costs vary from historical provisions for loss, future earnings will be charged or credited.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 11 – INSURANCE RISKS (Continued)

The provision for loss for insurance risks, including the cost of coverage maintained with unaffiliated commercial reinsurance and insurance carriers, follows (in thousands):

	Year ended December 31,		
	2016	2015	2014
Professional liability:			
Continuing operations	\$ 81,057	\$ 70,695	\$ 59,190
Discontinued operations	(3,703)	(4,053)	8,073
Workers compensation:			
Continuing operations	\$ 55,686	\$ 51,191	\$ 36,152
Discontinued operations	(1,868)	(3,695)	2,110

Changes in the allowance for professional liability risks and workers compensation risks for the years ended December 31 follow (including discontinued operations) (in thousands):

	2016			2015		
	Professional liability	Workers compensation	Total	Professional liability	Workers compensation	Total
Allowance for insurance risks at beginning of year	\$ 327,372	\$ 254,849	\$ 582,221	\$ 307,751	\$ 189,259	\$ 497,010
Provision for loss for retained insurance risks:						
Current year	66,750	52,754	119,504	55,498	55,172	110,670
Prior years	(2,310)	(14,018)	(16,328)	(1,173)	(18,151)	(19,324)
	<u>64,440</u>	<u>38,736</u>	<u>103,176</u>	<u>54,325</u>	<u>37,021</u>	<u>91,346</u>
Provision for reinsurance and insurance, administrative and overhead costs	12,914	15,082	27,996	12,317	10,475	22,792
Discount accretion	953	-	953	1,190	-	1,190
Contributions from managed facilities	273	496	769	220	344	564
Acquisitions	-	-	-	13,948	64,223	78,171
Payments for insurance risks:						
Current year	(3,884)	(12,026)	(15,910)	(6,158)	(11,483)	(17,641)
Prior years	(66,639)	(32,606)	(99,245)	(68,611)	(36,842)	(105,453)
	<u>(70,523)</u>	<u>(44,632)</u>	<u>(115,155)</u>	<u>(74,769)</u>	<u>(48,325)</u>	<u>(123,094)</u>
Payments for reinsurance and insurance, administrative and overhead costs	(12,914)	(15,082)	(27,996)	(12,317)	(10,475)	(22,792)
Change in reinsurance and other recoverables	38,080	15,759	53,839	24,707	12,327	37,034
Allowance for insurance risks at end of year	<u>\$ 360,595</u>	<u>\$ 265,208</u>	<u>\$ 625,803</u>	<u>\$ 327,372</u>	<u>\$ 254,849</u>	<u>\$ 582,221</u>

	2014		
	Professional liability	Workers compensation	Total
Allowance for insurance risks at beginning of year	\$ 307,223	\$ 187,637	\$ 494,860
Provision for loss for retained insurance risks:			
Current year	55,419	42,724	98,143
Prior years	291	(12,438)	(12,147)
	<u>55,710</u>	<u>30,286</u>	<u>85,996</u>
Provision for reinsurance and insurance, administrative and overhead costs	11,553	7,976	19,529
Discount accretion	1,409	-	1,409
Contributions from managed facilities	300	254	554
Acquisitions	-	-	-
Payments for insurance risks:			
Current year	(7,539)	(9,412)	(16,951)
Prior years	(70,526)	(24,594)	(95,120)
	<u>(78,065)</u>	<u>(34,006)</u>	<u>(112,071)</u>
Payments for reinsurance and insurance, administrative and overhead costs	(11,553)	(7,976)	(19,529)
Change in reinsurance and other recoverables	21,174	5,088	26,262
Allowance for insurance risks at end of year	<u>\$ 307,751</u>	<u>\$ 189,259</u>	<u>\$ 497,010</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 11 – INSURANCE RISKS (Continued)

A summary of the assets and liabilities related to insurance risks included in the accompanying consolidated balance sheet at December 31 follows (in thousands):

	2016			2015		
	Professional liability	Workers compensation	Total	Professional liability	Workers compensation	Total
Assets:						
Current:						
Insurance subsidiary investments	\$ 64,622	\$ 44,344	\$ 108,966	\$ 61,889	\$ 44,749	\$ 106,638
Reinsurance and other recoverables	7,912	1,488	9,400	9,282	1,020	10,302
Other	-	50	50	-	100	100
	72,534	45,882	118,416	71,171	45,869	117,040
Non-current:						
Insurance subsidiary investments	97,223	107,706	204,929	82,207	122,291	204,498
Reinsurance and other recoverables	111,596	101,984	213,580	90,387	86,943	177,330
Deposits	4,202	22,979	27,181	3,980	4,337	8,317
Other	-	-	-	-	38	38
	213,021	232,669	445,690	176,574	213,609	390,183
	\$ 285,555	\$ 278,551	\$ 564,106	\$ 247,745	\$ 259,478	\$ 507,223
Liabilities:						
Allowance for insurance risks:						
Current	\$ 65,284	\$ 48,237	\$ 113,521	\$ 64,099	\$ 48,770	\$ 112,869
Non-current	295,311	216,971	512,282	263,273	206,079	469,352
	\$ 360,595	\$ 265,208	\$ 625,803	\$ 327,372	\$ 254,849	\$ 582,221

Provisions for loss for professional liability risks retained by the Company's limited purpose insurance subsidiary have been discounted based upon actuarial estimates of claim payment patterns using a discount rate of 1%. The discount rate is based upon the risk-free interest rate for the respective year. Amounts equal to the discounted loss provision are funded annually. The Company does not fund the portion of professional liability risks related to estimated claims that have been incurred but not reported. Accordingly, these liabilities are not discounted. If the Company did not discount any of the allowances for professional liability risks, these balances would have approximated \$363.2 million at December 31, 2016 and \$329.9 million at December 31, 2015.

Provisions for loss for workers compensation risks retained by the Company's limited purpose insurance subsidiary are not discounted and amounts equal to the loss provision are funded annually.

NOTE 12 – INSURANCE SUBSIDIARY INVESTMENTS

The Company maintains investments, consisting principally of cash and cash equivalents, debt securities, equities and certificates of deposit for the payment of claims and expenses related to professional liability and workers compensation risks. These investments have been categorized as available-for-sale and are reported at fair value.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 12 – INSURANCE SUBSIDIARY INVESTMENTS (Continued)

The cost for equities, amortized cost for debt securities and estimated fair value of the Company's insurance subsidiary investments at December 31 follows (in thousands):

	2016				2015			
	Cost	Unrealized gains	Unrealized losses	Fair value	Cost	Unrealized gains	Unrealized losses	Fair value
Cash and cash equivalents (a)	\$ 185,152	\$ -	\$ -	\$ 185,152	\$ 186,029	\$ -	\$ -	\$ 186,029
Debt securities:								
Corporate bonds	55,239	37	(100)	55,176	46,940	5	(122)	46,823
U.S. Treasury notes	24,763	6	(42)	24,727	33,386	-	(55)	33,331
Debt securities issued by U.S. government agencies	18,344	7	(63)	18,288	22,497	-	(43)	22,454
	98,346	50	(205)	98,191	102,823	5	(220)	102,608
Equities by industry:								
Consumer	2,596	66	(150)	2,512	2,271	182	(36)	2,417
Technology	2,105	120	(23)	2,202	1,533	66	(98)	1,501
Financial services	1,641	213	(24)	1,830	1,854	55	(81)	1,828
Industrials	1,291	57	(19)	1,329	1,994	86	(157)	1,923
Healthcare	1,332	-	(86)	1,246	1,896	116	(37)	1,975
Energy	-	-	-	-	1,015	-	(15)	1,000
Other	6,530	109	(70)	6,569	3,849	26	(268)	3,607
	15,495	565	(372)	15,688	14,412	531	(692)	14,251
Certificates of deposit	14,850	14	-	14,864	8,250	-	(2)	8,248
	<u>\$ 313,843</u>	<u>\$ 629</u>	<u>\$ (577)</u>	<u>\$ 313,895</u>	<u>\$ 311,514</u>	<u>\$ 536</u>	<u>\$ (914)</u>	<u>\$ 311,136</u>

(a) Includes \$14.8 million and \$29.6 million of money market funds at December 31, 2016 and 2015, respectively.

The fair value by maturity periods at December 31, 2016 of available-for-sale investments of the Company's insurance subsidiary follows. Equities generally do not have maturity dates.

<u>(In thousands)</u>	<u>Contractual maturities</u>
Within one year	\$ 249,736
One year to five years	48,471
After five years	-
Equities	15,688
	<u>\$ 313,895</u>

Since the Company's insurance subsidiary investments are restricted for a limited purpose, they are classified in the accompanying consolidated balance sheet based upon the expected current and long-term cash requirements of the limited purpose insurance subsidiary.

Net investment income earned by the Company's insurance subsidiary investments follows (in thousands):

	Year ended December 31,		
	2016	2015	2014
Interest income	\$ 1,850	\$ 1,461	\$ 1,013
Net amortization of premium and accretion of discount	(252)	(348)	(325)
Gains on sale of investments	1,539	646	2,895
Losses on sale of investments	(173)	(33)	(92)
Other-than-temporary impairments	(160)	(440)	-
Investment expenses	(221)	(215)	(145)
	<u>\$ 2,583</u>	<u>\$ 1,071</u>	<u>\$ 3,346</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 12 – INSURANCE SUBSIDIARY INVESTMENTS (Continued)

The available-for-sale investments of the Company's insurance subsidiary which have unrealized losses at December 31, 2016, and 2015 are shown below. The investments are categorized by the length of time that individual securities have been in a continuous unrealized loss position at December 31, 2016 and 2015.

December 31, 2016	Less than one year		One year or greater		Total	
	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses
(In thousands)						
Debt securities:						
Corporate bonds	\$ 27,406	\$ 100	\$ -	\$ -	\$ 27,406	\$ 100
U.S. Treasury notes	11,120	42	-	-	11,120	42
Debt securities issued by U.S. government agencies	10,712	63	-	-	10,712	63
	<u>49,238</u>	<u>205</u>	<u>-</u>	<u>-</u>	<u>49,238</u>	<u>205</u>
Equities by industry:						
Consumer	1,294	150	-	-	1,294	150
Technology	459	23	-	-	459	23
Financial services	-	-	152	24	152	24
Industrials	-	-	422	19	422	19
Healthcare	1,246	86	-	-	1,246	86
Energy	-	-	-	-	-	-
Other	2,267	70	-	-	2,267	70
	<u>5,266</u>	<u>329</u>	<u>574</u>	<u>43</u>	<u>5,840</u>	<u>372</u>
Certificates of deposit	-	-	-	-	-	-
	<u>\$ 54,504</u>	<u>\$ 534</u>	<u>\$ 574</u>	<u>\$ 43</u>	<u>\$ 55,078</u>	<u>\$ 577</u>
December 31, 2015	Less than one year		One year or greater		Total	
	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses
(In thousands)						
Debt securities:						
Corporate bonds	\$ 42,299	\$ 104	\$ 878	\$ 18	\$ 43,177	\$ 122
U.S. Treasury notes	33,331	55	-	-	33,331	55
Debt securities issued by U.S. government agencies	20,503	43	-	-	20,503	43
	<u>96,133</u>	<u>202</u>	<u>878</u>	<u>18</u>	<u>97,011</u>	<u>220</u>
Equities by industry:						
Consumer	381	36	-	-	381	36
Technology	892	98	-	-	892	98
Financial services	860	81	-	-	860	81
Industrials	1,026	157	-	-	1,026	157
Healthcare	700	37	-	-	700	37
Energy	182	15	-	-	182	15
Other	2,990	268	-	-	2,990	268
	<u>7,031</u>	<u>692</u>	<u>-</u>	<u>-</u>	<u>7,031</u>	<u>692</u>
Certificates of deposit	4,848	2	-	-	4,848	2
	<u>\$ 108,012</u>	<u>\$ 896</u>	<u>\$ 878</u>	<u>\$ 18</u>	<u>\$ 108,890</u>	<u>\$ 914</u>

The unrealized losses on equities totaling \$0.4 million at December 31, 2016 and \$0.7 million at December 31, 2015 were due generally to market fluctuations. Accordingly, the Company believes these unrealized losses are temporary in nature.

The Company's investment policy governing insurance subsidiary investments precludes the investment portfolio managers from selling any security at a loss without prior authorization from the Company. The investment managers also limit the exposure to any one issue, issuer or type of investment. The Company intends, and has the ability, to hold insurance subsidiary investments for a long duration without the necessity of selling securities to fund the underwriting needs of its insurance subsidiary. This ability to hold securities allows sufficient time for recovery of temporary declines in the market value of equity securities and the par value of debt securities as of their stated maturity date.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 12 – INSURANCE SUBSIDIARY INVESTMENTS (Continued)

The Company considered the severity and duration of its unrealized losses at December 31, 2016 and December 31, 2015 and recognized pretax other-than-temporary impairments during 2016 and 2015 of \$0.2 million and \$0.4 million, respectively, for various investments held in its insurance subsidiary investment portfolio. These investments were determined to be impaired after considering the duration of the declines in value and the likelihood of near term price recovery of each investment. The Company considered the severity and duration of its unrealized losses at December 31, 2014 for various investments held in its insurance subsidiary investment portfolio and determined that these unrealized losses were temporary and did not record any impairment losses related to these investments. Because the Company considered the remaining unrealized losses at December 31, 2016 and December 31, 2015 to be temporary, the Company did not record any additional impairment losses related to these investments.

NOTE 13 – LEASES

The Company leases real estate and equipment under cancelable and non-cancelable arrangements. The following table sets forth rent expense by business segment (in thousands):

	Year ended December 31,		
	2016	2015	2014
Kindred at Home:			
Home health:			
Buildings	\$ 33,027	\$ 31,315	\$ 7,027
Equipment	1,301	1,607	805
	<u>34,328</u>	<u>32,922</u>	<u>7,832</u>
Hospice:			
Buildings	17,105	16,219	895
Equipment	334	420	55
	<u>17,439</u>	<u>16,639</u>	<u>950</u>
Hospital division:			
Buildings:			
Ventas	118,053	118,511	118,130
Other landlords	55,554	55,979	56,210
Equipment	33,456	31,995	30,823
	<u>207,063</u>	<u>206,485</u>	<u>205,163</u>
Kindred Rehabilitation Services:			
Kindred Hospital Rehabilitation Services:			
Buildings	33,710	29,423	6,488
Equipment	1,567	1,357	553
	<u>35,277</u>	<u>30,780</u>	<u>7,041</u>
RehabCare:			
Buildings	1,276	1,236	1,314
Equipment	2,361	2,589	2,885
	<u>3,637</u>	<u>3,825</u>	<u>4,199</u>
Nursing center division:			
Buildings:			
Ventas	44,331	43,948	43,809
Other landlords	38,178	34,046	33,165
Equipment	8,347	7,891	8,348
	<u>90,856</u>	<u>85,885</u>	<u>85,322</u>
Support center:			
Buildings	1,808	3,233	2,109
Equipment	126	120	176
	<u>1,934</u>	<u>3,353</u>	<u>2,285</u>
Totals:			
Buildings:			
Ventas	162,384	162,459	161,939
Other landlords	180,658	171,451	107,208
Equipment	47,492	45,979	43,645
	<u>\$ 390,534</u>	<u>\$ 379,889</u>	<u>\$ 312,792</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 13 – LEASES (Continued)

Various facility leases include contingent annual rent escalators based upon a change in the Consumer Price Index or other agreed upon terms such as a patient revenue test. These contingent rents are included in rent expense in the year incurred. The Company recorded contingent rent of \$0.8 million, \$0.5 million and \$0.8 million for the years ended December 31, 2016, 2015 and 2014, respectively, including both continuing operations and discontinued operations.

Future minimum payments under non-cancelable operating leases are as follows (in thousands):

	Minimum payments		
	Ventas	Other	Total
2017	\$ 157,956	\$ 158,583	\$ 316,539
2018	159,165	142,751	301,916
2019	160,156	130,075	290,231
2020	161,834	116,563	278,397
2021	163,210	92,532	255,742
Thereafter	502,499	390,684	893,183

Ventas master lease agreements

At December 31, 2016, the Company leased from Ventas and its affiliates 36 nursing centers and 30 TC hospitals under four master lease agreements (the “Master Lease Agreements”). Currently, 11 nursing centers are leased under Master Lease Agreement No. 1, 10 nursing centers are leased under Master Lease Agreement No. 2, four nursing centers are leased under Master Lease Agreement No. 4, and 11 nursing centers and all 30 TC hospitals are leased under Master Lease Agreement No. 5.

Each Master Lease Agreement includes land, buildings, structures, and other improvements on the land, easements, and similar appurtenances to the land and improvements, and permanently affixed equipment, machinery, and other fixtures relating to the operation of the leased properties. There are one or more bundles of leased properties under each Master Lease Agreement, with each bundle containing leased nursing centers or TC hospitals.

Recent master lease amendments

On November 11, 2016, as part of the Company’s strategic decision to exit the skilled nursing facility business, the Company entered into an agreement with Ventas which provides it with the option to acquire the real estate for all 36 skilled nursing facilities (the “Ventas SNFs”) currently leased under the Master Lease Agreements for an aggregate consideration of \$700 million. The agreement also provides that, through October 31, 2018, the Company has the right to find one or more purchasers of the Ventas SNFs. As the Company locates new owners/operators for the Ventas SNFs, in exchange for the Company’s payment to Ventas of the allocable portion of the \$700 million purchase price, Ventas has agreed to convey the real estate for the applicable Ventas SNF to the new owner/operator. The Company, at its option, may also elect to renew the leases for any of the Ventas SNFs through April 30, 2025, and transfer them into Master Lease Agreement No. 5. The Ventas SNFs will remain leased under their current Master Lease Agreements until the Company exercises its purchase option or April 30, 2018, whichever comes first. If the Company does not complete the acquisition of the Ventas SNFs by April 30, 2018, the lease for any remaining Ventas SNFs will be automatically renewed through April 30, 2025, and transferred into Master Lease Agreement No. 5. Since all of the Ventas SNFs will either be sold or transferred into Master Lease Agreement No. 5, Kindred’s other Master Lease Agreements with Ventas will be effectively terminated and only Master Lease Agreement No. 5 will remain.

Also on November 11, 2016, the Company renewed the leases for eight TC hospitals it leased from Ventas (the “Renewed Hospitals”) through April 30, 2025, and transferred the Renewed Hospitals into Master Lease Agreement No. 5, which was amended and restated. The Renewed Hospitals were previously leased under Master Lease Agreements Nos. 1, 2 and 4, each of which was amended on November 11, 2016. The base rent and rent escalators remained the same for the Renewed Hospitals, as well as for the other 22 TC hospitals currently in Master Lease Agreement No. 5. The Renewed Hospitals were combined into a single renewal bundle with 16 of the Company’s other TC hospitals expiring on April 30, 2025. Master Lease Agreement No. 5 also contains one additional renewal bundle with six TC hospitals expiring on April 30, 2023. The amended and restated Master Lease Agreement No. 5 contains terms substantially similar to the existing Master Lease Agreement No. 5, except for modifications to certain restrictions applicable to the Company that will take effect if all of the Ventas SNFs are acquired and Ventas receives the aggregate consideration.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 13 – LEASES (Continued)

Recent master lease amendments (Continued)

In connection with the Curahealth Disposal, the Company entered into amendments to certain of its Master Lease Agreements on April 3, 2016 to transition the operations for seven TC hospitals (the “Leased Hospitals”). Six of the Leased Hospitals were leased under Master Lease Agreement No. 5 and one was leased under Master Lease Agreement No. 1. The Leased Hospitals were leased under the applicable Master Lease Agreement until the closing of the Curahealth Disposal on October 1, 2016. The Company paid a fee to Ventas of \$3.5 million upon signing of the amendments and paid an additional \$3 million upon the closing of the sale of the Leased Hospitals. Ventas paid the Company 50% of the sales proceeds for the real estate (after deduction of its closing costs) attributed to the Leased Hospitals in the sale, which was immaterial. Under separate lease amendments, the annual rent on the Leased Hospitals, which had annual rent of \$7.7 million, was reallocated to the remaining facilities the Company leases from Ventas under the various Master Lease Agreements. As required under GAAP, the reallocated rents were recorded as a lease termination fee by the Company upon the cease use date of the Leased Hospitals.

In connection with these transactions, the Company incurred a pretax lease termination fee of \$52.3 million comprised of the \$6.5 million of fees paid to Ventas in conjunction with execution of the amendments and \$45.8 million of aggregate reallocated rents attributable to the Leased Hospitals, which was recorded upon the cease use date of the Leased Hospitals. The lease termination fee was recorded as a long-term liability discounted at the Company’s credit-adjusted risk-free rate through the end of the original lease term of the Leased Hospitals, or through 2025. These lease termination fees were recorded as restructuring charges in the accompanying consolidated statement of operations.

Rental amounts and escalators

Each Master Lease Agreement is commonly known as a triple-net lease or an absolute-net lease. Accordingly, in addition to rent, the Company is required to pay the following: (1) all insurance required in connection with the leased properties and the business conducted on the leased properties, (2) certain taxes levied on or with respect to the leased properties (other than taxes on the income of Ventas), and (3) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties.

The Company paid rents to Ventas (including amounts classified within discontinued operations) approximating \$167.7 million for the year ended December 31, 2016, \$171.8 million for the year ended December 31, 2015, and \$192.1 million for the year ended December 31, 2014.

Each Master Lease Agreement provides for rent escalations each May 1. All annual rent escalators are payable in cash. The contingent annual rent escalator is 2.7% for Master Lease Agreements Nos. 1 and 4. The contingent annual rent escalator for Master Lease Agreement No. 2 is based upon the Consumer Price Index with a floor of 2.25% and a ceiling of 4%. The contingent annual rent escalator for Master Lease Agreement No. 5 is based upon annual increases in the Consumer Price Index, subject to a ceiling of 4%. In 2016, the contingent annual rent escalator was 2.25% for Master Lease Agreement No. 2 and 1.02% for Master Lease Agreement No. 5.

NOTE 14 – LONG-TERM DEBT

Capitalization

A summary of long-term debt at December 31 follows (in thousands):

	2016	2015
Term Loan Facility due 2021, net of unamortized original issue discount of \$6.7 million at December 31, 2016 and \$6.2 million at December 31, 2015	\$ 1,362,772	\$ 1,176,789
8.00% Notes due 2020	750,000	750,000
8.75% Notes due 2023	600,000	600,000
6.375% Notes due 2022	500,000	500,000
ABL Facility	62,500	108,600
Mandatory Redeemable Preferred Stock (see Note 15)	12,372	23,886
Capital lease obligations	580	848
Other	1,446	1,532
Debt issuance costs, net of accumulated amortization	(46,631)	(50,677)
Total debt, average life of 4 years (weighted average rate 6.5% for 2016 and 6.4% for 2015)	3,243,039	3,110,978
Amounts due within one year	(27,977)	(24,630)
Long-term debt	<u>\$ 3,215,062</u>	<u>\$ 3,086,348</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 14 – LONG-TERM DEBT (Continued)

Capitalization (Continued)

The following table summarizes scheduled maturities of long-term debt (in thousands):

	Term Loan Facility due 2021	8.00% Notes due 2020	8.75% Notes due 2023	6.375% Notes due 2022	ABL Facility	Mandatory Redeemable Preferred Stock	Capital lease obligations	Other	Total
2017	\$ 14,034	\$ -	\$ -	\$ -	\$ -	\$ 12,372	\$ 268	\$ 1,303	\$ 27,977
2018	14,034	-	-	-	-	-	210	143	14,387
2019	14,034	-	-	-	62,500	-	102	-	76,636
2020	14,034	750,000	-	-	-	-	-	-	764,034
2021	1,313,326	-	-	-	-	-	-	-	1,313,326
Thereafter	-	-	600,000	500,000	-	-	-	-	1,100,000
	<u>\$ 1,369,462</u>	<u>\$ 750,000</u>	<u>\$ 600,000</u>	<u>\$ 500,000</u>	<u>\$ 62,500</u>	<u>\$ 12,372</u>	<u>\$ 580</u>	<u>\$ 1,446</u>	<u>\$ 3,296,360</u>

The estimated fair value of the Company's long-term debt approximated \$3.2 billion and \$3.0 billion at December 31, 2016 and December 31, 2015, respectively. See Note 20.

Credit Facilities

As used herein, the "Credit Facilities" refers collectively to the Term Loan Facility and the ABL Facility, in each case as defined and described below.

Term Loan Facility

As used herein, "Term Loan Facility" means the Company's \$1.37 billion term loan credit facility provided pursuant to the terms and provisions of that certain Term Loan Credit Agreement dated as of June 14, 2016 (the "Term Loan Credit Agreement"), among the Company, the lenders from time to time party thereto, and JPMorgan Chase Bank, N.A., as administrative agent and collateral agent. All obligations under the Company's Term Loan Facility are fully and unconditionally guaranteed, subject to certain customary release provisions, by substantially all of the Company's wholly owned, domestic material subsidiaries, as well as certain non-wholly owned domestic subsidiaries as the Company may determine from time to time in its sole discretion.

The Company's Term Loan Facility (1) matures on April 9, 2021, (2) contains financial maintenance covenants in the form of a maximum total leverage ratio, a minimum fixed charge coverage ratio and a maximum amount of annual capital expenditures, (3) imposes restrictions on the Company's ability to incur debt and liens and make acquisitions, investments and payments on equity and junior debt, and (4) provides for interest rate margins of 3.25% for the London Interbank Offered Rate ("LIBOR") borrowings (subject to a floor of 1.00%) and 2.25% for base rate borrowings.

A summary of the amendments to the Company's Term Loan Facility since January 1, 2014 is set forth below.

On June 14, 2016, the Company entered into the Term Loan Credit Agreement that amended and restated the Term Loan Facility to provide for, among other things, (1) additional joint venture flexibility, including an increased ability to enter into and make investments in joint ventures that are non-guarantor restricted subsidiaries and to incur debt and liens of such joint ventures and other non-guarantor restricted subsidiaries, (2) an increase in the size of a basket for asset sales from 15% to 25% of consolidated total assets, (3) maintaining a maximum total leverage ratio of 6.00:1.00 for each quarterly measurement date after the date of such amendment, and (4) an incremental term loan in an aggregate principal amount of \$200 million. The incremental term loan was issued with 95 basis points of original issue discount ("OID") and has the same terms as, and is fungible with, the \$1.18 billion in aggregate principal amount of term loans that were outstanding under the Term Loan Facility immediately prior to the effectiveness of the Term Loan Credit Agreement. The net proceeds from the incremental term loan were used to repay a portion of the outstanding borrowings under the Company's ABL Facility.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 14 – LONG-TERM DEBT (Continued)

Credit Facilities (Continued)

Term Loan Facility (Continued)

On March 10, 2015, the Company entered into an incremental amendment agreement to the Term Loan Facility that provided for an incremental term loan in an aggregate principal amount of \$200 million under the Company's Term Loan Facility. The Company used the net proceeds of the incremental term loan to repay outstanding borrowings under its ABL Facility. The incremental term loan was issued with 50 basis points of OID and has the same terms as, and is fungible with, the other term loans outstanding under the Company's Term Loan Facility.

On November 25, 2014, the Company entered into an amendment and restatement agreement that, among other items, (1) modified certain provisions related to the issuance of notes into escrow accounts, (2) increased the applicable interest rate margins for the LIBOR borrowings from 3.00% to 3.25% and for base rate borrowings from 2.00% to 2.25%, (3) temporarily increased the maximum total leverage ratio permitted under the financial maintenance covenants, and (4) modified certain provisions related to the incurrence of debt and the making of acquisitions, investments and restricted payments.

On April 9, 2014, the Company entered into an amendment and restatement agreement that, among other items, (1) extended the maturity date from June 1, 2018 to April 9, 2021, (2) provided for the replacement of all term loans outstanding under the Term Loan Facility with new term loans in a principal amount of \$1 billion, (3) reduced the applicable margin for LIBOR borrowings from 3.25% to 3.00% and, with respect to base rate borrowings, from 2.25% to 2.00%, (4) increased the available capacity for incremental term loans, and (5) amended certain provisions related to the incurrence of debt and liens and the making of acquisitions, investments and restricted payments.

Unamortized deferred financing costs and OID related to the Company's Term Loan Facility totaling \$5.0 million (\$3.1 million net of income taxes) were written off and recorded as interest expense during the year ended December 31, 2014.

ABL Facility

As used herein, "ABL Facility" means the Company's \$900 million asset-based loan revolving credit facility provided pursuant to the terms and provisions of that certain ABL Credit Agreement dated as of June 14, 2016 (the "ABL Credit Agreement") among the Company, the lenders party thereto from time to time, and JPMorgan Chase Bank, N.A., as administrative agent and collateral agent. All obligations under the Company's ABL Facility are fully and unconditionally guaranteed, subject to certain customary release provisions, by substantially all of the Company's wholly owned, domestic material subsidiaries, as well as certain non-wholly owned domestic subsidiaries as the Company may determine from time to time in its sole discretion.

The Company's ABL Facility (1) matures on April 9, 2019, (2) contains financial maintenance covenants in the form of a minimum fixed charge coverage ratio and a maximum amount of annual capital expenditures, (3) imposes restrictions on the Company's ability to incur debt and liens and make acquisitions, investments and payments on equity and junior debt, and (4) provides for interest rate margins of 2.00% to 2.50% for LIBOR borrowings and 1.00% to 1.50% for base rate borrowings (in each case depending on average daily excess availability).

A summary of ABL Facility amendments since 2014 are set forth below.

On June 14, 2016, the Company entered into the ABL Credit Agreement that amended and restated the ABL facility to provide for, among other things, (1) additional joint venture flexibility, including an increased ability to enter into and make investments in joint ventures that are non-guarantor restricted subsidiaries and to incur debt and liens of such joint ventures and other non-guarantor restricted subsidiaries, and (2) an increase in the size of a basket for asset sales from 15% to 25% of consolidated total assets.

On June 3, 2015, the Company entered into an amendment agreement to the ABL Facility that among other items, modified the restrictions on the amount of cash and temporary cash investments that may be held outside of certain deposit accounts subject to control agreements.

On December 12, 2014, the Company entered into the incremental joinder agreement to the ABL Facility that provided for, upon consummation of the Gentiva Merger and the satisfaction of certain other conditions, additional revolving commitments in an aggregate principal amount of \$150 million under the ABL Facility.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 14 – LONG-TERM DEBT (Continued)

Credit Facilities (Continued)

ABL Facility (Continued)

On October 31, 2014, the Company entered into an amendment and restatement agreement that, among other items, (1) modified certain provisions related to the issuance of notes into escrow accounts, and (2) upon the consummation of the Gentiva Merger and the satisfaction of certain other conditions, modified certain provisions related to the incurrence of debt and the making of acquisitions, investments and restricted payments.

On April 9, 2014, the Company entered into an amendment and restatement agreement that, among other items, (1) extended the maturity date of the ABL Facility from June 1, 2018 to April 9, 2019, (2) provided for the replacement of all revolving commitments outstanding under the ABL Facility with new revolving commitments in the same principal amount, (3) increased the amounts available for incremental commitments, (4) amended certain provisions related to the incurrence of debt and liens and the making of acquisitions, investments and restricted payments, (5) reduced the applicable interest rate margins for LIBOR borrowings from a range of 2.50% to 3.00% (depending on average daily excess availability) to a range of 2.00% to 2.50%, and (6) reduced the applicable interest rate margins for base rate borrowings from a range of 1.50% to 2.00% (depending on average daily excess availability) to a range from 1.00% to 1.50%.

Unamortized deferred financing costs related to the Company's ABL Facility totaling \$0.6 million (\$0.4 million net of income taxes) were written off and recorded as interest expense during the year ended December 31, 2014.

Gentiva Merger – Gentiva Financing Transactions

The following transactions (collectively, the "Gentiva Financing Transactions") occurred in connection with the Gentiva Merger:

- the Company issued \$1.35 billion aggregate principal amount of the Notes (as defined below);
- the Company issued approximately 15 million shares of its Common Stock through two common stock offerings (see Note 17) and issued 9.7 million shares of its Common Stock through the Stock Consideration (see Note 2);
- the Company issued 172,500 tangible equity units (the "Units") (see Note 15); and
- the Company amended its ABL Facility in October 2014 and Term Loan Facility in November 2014.

Notes due 2020 and Notes due 2023 Offerings

On December 18, 2014, Kindred Escrow Corp. II (the "Escrow Issuer"), one of the Company's subsidiaries, completed a private placement of \$750 million aggregate principal amount of 8.00% Senior Notes due 2020 (the "Notes due 2020") and \$600 million aggregate principal amount of 8.75% Senior Notes due 2023 (the "Notes due 2023", and, together with the Notes due 2020, the "Notes"). The Notes due 2020 were issued pursuant to the indenture, dated as of December 18, 2014 (the "2020 Indenture"), between the Escrow Issuer and Wells Fargo Bank, National Association, as trustee. The Notes due 2023 were issued pursuant to the indenture, dated as of December 18, 2014 (the "2023 Indenture" and, together with the 2020 Indenture, the "Indentures"), between the Escrow Issuer and Wells Fargo Bank, National Association.

The Notes were assumed by the Company and fully and unconditionally guaranteed on a senior unsecured basis by substantially all of the Company's wholly owned, domestic material subsidiaries, including substantially all of the Company's and Gentiva's wholly owned, domestic material subsidiaries (the "Guarantors"), ranking *pari passu* with all of the Company's respective existing and future senior unsubordinated indebtedness. On October 30, 2015, the Company completed a registered exchange offer to exchange the Notes for registered notes with substantially identical terms.

The Indentures contain certain restrictive covenants that limit the Company and its restricted subsidiaries' ability to, among other things, incur, assume or guarantee additional indebtedness; pay dividends, make distributions or redeem or repurchase capital stock; effect dividends, loans or asset transfers from its subsidiaries; sell or otherwise dispose of assets; and enter into transactions with affiliates. These covenants are subject to a number of limitations and exceptions. The Indentures also contain customary events of default.

Under the terms of the Indentures, the Company may pay dividends pursuant to specified exceptions, including if its consolidated coverage ratio (as defined therein) is at least 2.0 to 1.0, it may also pay dividends in an amount equal to 50% of its consolidated net income (as defined therein) and 100% of the net cash proceeds from the issuance of capital stock, in each case since January 1, 2014. The making of certain other restricted payments or investments by the Company or its restricted subsidiaries would reduce the amount available for the payment of dividends pursuant to the foregoing exception.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 14 – LONG-TERM DEBT (Continued)

Notes due 2022

On April 9, 2014, the Company completed a private placement of \$500 million aggregate principal amount of 6.375% senior notes due 2022 (the “Notes due 2022”). The Notes due 2022 were issued pursuant to the indenture dated April 9, 2014 (the “2022 Indenture”) among the Company, the guarantors party thereto (the “2022 Guarantors”) and Wells Fargo Bank, National Association, as trustee.

The Notes due 2022 bear interest at an annual rate of 6.375% and are senior unsecured obligations of the Company and of the 2022 Guarantors. The 2022 Indenture contains certain restrictive covenants that, among other things, limits the Company and its restricted subsidiaries’ ability to incur, assume or guarantee additional indebtedness; pay dividends, make distributions or redeem or repurchase capital stock; effect dividends, loans or asset transfers from the Company’s subsidiaries; sell or otherwise dispose of assets; and enter into transactions with affiliates. These covenants are subject to a number of limitations and exceptions. The 2022 Indenture also contains customary events of default. The Notes due 2022 are fully and unconditionally guaranteed, subject to customary release provisions, by substantially all of the Company’s wholly owned, domestic material subsidiaries. On January 28, 2015, the Company completed a registered exchange offer to exchange each of the Notes due 2022 for registered notes with substantially identical terms.

Under the terms of the Notes due 2022, the Company may pay dividends pursuant to specified exceptions, including if its consolidated coverage ratio (as defined therein) is at least 2.0 to 1.0, the Company may pay dividends in an amount equal to 50% of its consolidated net income (as defined therein) and 100% of the net cash proceeds from the issuance of capital stock. The making of certain other restricted payments or investments by the Company or its restricted subsidiaries would reduce the amount available for the payment of dividends pursuant to the foregoing exception.

On January 30, 2015, following the receipt of sufficient consents to approve the proposed amendments, the Company, the 2022 Guarantors and Wells Fargo Bank, National Association, as trustee, entered into the first supplemental indenture (the “2022 Supplemental Indenture”) to the 2022 Indenture. The 2022 Supplemental Indenture conforms certain covenants, definitions and other terms in the 2022 Indenture to the covenants, definitions and terms contained in the Indentures governing the Notes. The 2022 Supplemental Indenture became operative following the consummation of the Gentiva Merger.

Unamortized deferred financing costs totaling \$10.7 million (\$6.6 million net of income taxes), the applicable premium totaling \$36.4 million (\$22.5 million net of income taxes) and interest expense for the period from April 9, 2014 to May 9, 2014 totaling \$3.9 million (\$2.4 million net of income taxes), all related to the Company’s prior \$550 million, 8.25% senior notes due 2019, were written off and recorded as interest expense during the year ended December 31, 2014.

Interest rate swaps

In January 2016, the Company entered into three interest rate swap agreements to hedge its floating interest rate on an aggregate of \$325 million of outstanding Term Loan Facility debt, which replaced the previous \$225 million aggregate swap that expired on January 11, 2016. The interest rate swaps have an effective date of January 11, 2016, and expire on January 9, 2021. The Company is required to make payments based upon a fixed interest rate of 1.862% and 1.855% calculated on the notional amount of \$175 million and \$150 million, respectively. In exchange, the Company will receive interest on \$325 million at a variable interest rate that is based upon the three-month LIBOR rate, subject to a minimum rate of 1.0%.

In March 2014, the Company entered into an interest rate swap agreement to hedge its floating interest rate on an aggregate of \$400 million of outstanding Term Loan Facility debt. On April 8, 2014, the Company completed a novation of a portion of its \$400 million swap agreement to two new counterparties, each in the amount of \$125 million. The original swap contract was not amended, terminated or otherwise modified. The interest rate swap had an effective date of April 9, 2014 and will expire on April 9, 2018 and continues to apply to the Term Loan Facility. The Company is required to make payments based upon a fixed interest rate of 1.867% calculated on the notional amount of \$400 million. In exchange, the Company will receive interest on \$400 million at a variable interest rate that was based upon the three-month LIBOR, subject to a minimum rate of 1.0%.

The interest rate swaps were assessed for hedge effectiveness for accounting purposes and the Company determined the interest rate swaps qualify for cash flow hedge accounting at December 31, 2016. The Company records the effective portion of the gain or loss on these derivative financial instruments in accumulated other comprehensive income (loss) as a component of stockholders’ equity and records the ineffective portion of the gain or loss on these derivative financial instruments as interest expense. For the years ended December 31, 2016, 2015, and 2014, the ineffectiveness related to the interest rate swaps was immaterial.

The aggregate fair value of the interest rate swaps recorded in other accrued liabilities was \$2.7 million and \$4.5 million at December 31, 2016 and December 31, 2015, respectively.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 15 – TANGIBLE EQUITY UNITS

On November 25, 2014, in an offering registered with the Securities and Exchange Commission (the “SEC”), the Company completed the sale of 150,000 Units for cash and granted the underwriters a 13-day over-allotment option to purchase up to an additional 22,500 Units. On December 1, 2014, the underwriters exercised in full their over-allotment option to purchase 22,500 additional Units, which the Company closed on December 3, 2014. Each Unit is composed of a prepaid stock purchase contract (a “Purchase Contract”) and one share of 7.25% Mandatory Redeemable Preferred Stock, Series A (the “Mandatory Redeemable Preferred Stock”) having a final preferred stock installment payment date of December 1, 2017 and an initial liquidation preference of \$201.58 per share of Mandatory Redeemable Preferred Stock. The net proceeds from this offering, after deducting the underwriting discount and offering expenses, were \$166.3 million.

The Purchase Contracts were recorded as capital in excess of par value, net of issuance costs, and the Mandatory Redeemable Preferred Stock has been recorded as long-term debt. Issuance costs associated with the Mandatory Redeemable Preferred Stock were recorded as deferred financing costs within long-term debt on the consolidated balance sheet and are being amortized using the effective interest method as interest expense over the term of the instrument. On the issuance date, the Company allocated the proceeds of the Units to equity and debt based on the relative fair values of the respective components of each Unit. The aggregate values assigned upon issuance of each component of the Units were as follows (amounts in thousands except price per Unit):

	Purchase Contracts (equity component)	Mandatory Redeemable Preferred Stock (debt component)	Total
Price per Unit	\$ 798.42	\$ 201.58	\$ 1,000.00
Gross proceeds	\$ 137,727	\$ 34,773	\$ 172,500
Issuance costs	(4,938)	(1,247)	(6,185)
	<u>\$ 132,789</u>	<u>\$ 33,526</u>	<u>\$ 166,315</u>
Balance sheet impact at issuance:			
Long-term debt (deferred financing fees)	\$ -	\$ 1,247	\$ 1,247
Current portion of long-term debt	-	10,887	10,887
Long-term debt	-	23,886	23,886
Capital in excess of par value	132,789	-	132,789

Dividends on each share of Mandatory Redeemable Preferred Stock accumulate on the outstanding liquidation preference at a rate of 7.25% per annum. On March 1, June 1, September 1 and December 1 of each year, commencing on March 1, 2015, the Company will pay equal quarterly cash installments of \$18.75 per share of Mandatory Redeemable Preferred Stock (except for the March 1, 2015 installment payment, which was \$20.00 per share of Mandatory Redeemable Preferred Stock), in each case, to the extent that the Company has funds lawfully available for such purpose with respect to any such payments in cash and, with respect to the dividend portion of such payment, such dividend is declared by the Company’s Board of Directors. Each installment payment will constitute a payment of dividends (recorded as interest expense) and a payment of consideration for the partial reduction in liquidation preference of the Mandatory Redeemable Preferred Stock.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 15 – TANGIBLE EQUITY UNITS (Continued)

Unless settled earlier or redeemed at the holder's or the Company's option, each Purchase Contract will automatically settle on December 1, 2017, and the Company will deliver not more than 50.6329 shares and not less than 43.0918 shares of its Common Stock per Purchase Contract. If any holder elects to settle any or all of its Purchase Contracts early, the Company will deliver 43.0918 shares of Common Stock per Purchase Contract. See Note 17. For each Purchase Contract that is not settled early, the number of shares of the Company's Common Stock issuable upon mandatory settlement of each Purchase Contract (the "Settlement Amount") will be determined as follows:

- if the applicable market value is greater than \$23.21 per share, a number of shares of the Company's Common Stock equal to 43.0918 shares of Common Stock;
- if the applicable market value is less than or equal to \$23.21 per share but greater than or equal to \$19.75 per share, a number of shares of the Company's Common Stock equal to \$1,000 divided by the applicable market value; and
- if the applicable market value is less than \$19.75 per share, a number of shares of the Company's Common Stock equal to 50.6329 shares of Common Stock.

The term "applicable market value" means the average of the daily volume weighted average price ("VWAP") of the Company's Common Stock for the 20 consecutive trading day period beginning on, and including, the 23rd scheduled trading day immediately preceding December 1, 2017.

The term VWAP of the Company's Common Stock means, on any date of determination, the per share volume weighted average price as displayed under the heading Bloomberg VWAP on Bloomberg page "KND <equity> AQR" (or its equivalent successor if such page is not available) in respect of the period from the scheduled open of trading on the relevant trading day until the scheduled close of trading on the relevant trading day (or if such volume weighted average price is unavailable, the market price of one share of the Company's Common Stock on such trading day determined, using a volume-weighted average method, by a nationally recognized independent investment banking firm retained for this purpose by the Company).

Following the Gentiva Merger, the Company includes the minimum number of shares to be issued under the Purchase Contracts in the denominator of the calculation of basic earnings per share. Diluted earnings per share, when applicable, will include the weighted average number of common shares used in the basic denominator adjusted for the assumed number of shares that would be issued on the balance sheet date as determined by the Settlement Amount.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 16 – CONTINGENCIES

Management continually evaluates contingencies based upon the best available information. In addition, allowances for losses are provided currently for disputed items that have continuing significance, such as certain third party reimbursements and deductions that continue to be claimed in current cost reports and tax returns.

Management believes that allowances for losses have been provided to the extent necessary and that its assessment of contingencies is reasonable.

Principal contingencies are described below:

Revenues – Certain third party payments are subject to examination by agencies administering the various reimbursement programs. The Company is contesting certain issues raised in audits of prior year cost reports and the denial of payment by third parties to the Company's customers.

Professional liability risks – The Company has provided for losses for professional liability risks based upon management's best available information including actuarially determined estimates. Ultimate claims costs may differ from the provisions for loss. See Notes 6 and 11.

Legal and regulatory proceedings – The Company is a party to various legal actions and regulatory and other governmental and internal audits and investigations in the ordinary course of business (including investigations resulting from the Company's obligation to self-report suspected violations of law). The Company cannot predict the ultimate outcome of pending litigation and regulatory and other governmental and internal audits and investigations. The U.S. Department of Justice (the "DOJ"), CMS or other federal and state enforcement and regulatory agencies may conduct additional investigations related to the Company's businesses in the future. These matters could potentially subject the Company to sanctions, damages, recoupments, fines, and other penalties (some of which may not be covered by insurance), which may, either individually or in the aggregate, have a material adverse effect on the Company's business, financial position, results of operations, and liquidity. See Note 23.

Other indemnifications – In the ordinary course of business, the Company enters into contracts containing standard indemnification provisions and indemnifications specific to a transaction, such as a disposal of an operating facility. These indemnifications may cover claims related to employment-related matters, governmental regulations, environmental issues and tax matters, as well as patient, third party payor, supplier and contractual relationships. The Company also is subject to indemnity claims under contracts with its Kindred Rehabilitation Services division customers related to the provision of its services. Obligations under these indemnities generally are initiated by a breach of the terms of a contract or by a third party claim or event. These indemnifications could potentially subject the Company to damages and other payments which may, either individually or in the aggregate, have a material adverse effect on the Company's business, financial position, results of operations or liquidity.

Income taxes – The Company is subject to various federal and state income tax audits in the ordinary course of business. Such audits could result in increased tax payments, interest and penalties.

NOTE 17 – CAPITAL STOCK

Gentiva Merger – Stock Consideration

In connection with the Gentiva Merger, Kindred issued 9.7 million shares of Common Stock as part of the Stock Consideration. See Note 2.

Common Stock Offerings

On November 25, 2014, in an offering registered with the SEC, the Company completed the sale of 5,000,000 shares of its Common Stock for cash and granted the underwriters a 30-day over-allotment option to purchase up to an additional 750,000 shares of Common Stock. On December 1, 2014, the underwriters exercised their over-allotment option to purchase 395,759 additional shares of Common Stock, which the Company closed on December 3, 2014. The net proceeds of this offering, after deducting the underwriting discount and offering expenses, were \$101.0 million.

On June 25, 2014, in an offering registered with the SEC, the Company completed the sale of 9,000,000 shares of its Common Stock for cash and granted the underwriters a 30-day option to purchase up to an additional 1,350,000 shares of Common Stock, of which 723,468 shares were purchased on July 14, 2014. The net proceeds of this offering, after deducting the underwriting discount and offering expenses, were \$220.4 million.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 17 – CAPITAL STOCK (Continued)

Units Offering

On November 25, 2014, in an offering registered with the SEC, the Company completed the sale of 150,000 Units for cash and granted the underwriters a 13-day over-allotment option to purchase up to an additional 22,500 Units. On December 1, 2014, the underwriters exercised in full their over-allotment option to purchase 22,500 additional Units, which the Company closed on December 3, 2014. Each Unit is composed of a Purchase Contract and one share of Mandatory Redeemable Preferred Stock having a final preferred stock installment payment date of December 1, 2017 and an initial liquidation preference of \$201.58 per share of Mandatory Redeemable Preferred Stock. The net proceeds from the Units Offering, after deducting the underwriting discount and offering expenses, were \$166.3 million. See Note 15.

As of December 31, 2016, holders of 85,121 Purchase Contracts had elected early settlement. As a result, holders thereof received 43,0918 shares of Common Stock per Purchase Contract, resulting in approximately 3.7 million shares of Common Stock being issued by the Company.

Dividends and Other Payments

In February 2017, the Company's Board of Directors approved the cash dividend to its shareholders of \$0.12 per share of Common Stock to be paid on March 31, 2017 to shareholders of record as of the close of business on March 13, 2017. The Company's Board of Directors has elected, following the March 31, 2017 cash dividend payment on its Common Stock, to discontinue paying dividends on the Company's Common Stock and will instead redirect funds to repay debt and invest in growth.

During 2016, the Company paid cash dividends of \$0.12 per share of Common Stock on each of the following dates: December 9, 2016, September 2, 2016, June 10, 2016 and April 1, 2016.

During 2015, the Company paid cash dividends of \$0.12 per share of Common Stock on each of the following dates: December 11, 2015, September 4, 2015, June 10, 2015 and April 1, 2015.

During 2014, the Company paid cash dividends of \$0.12 per share of Common Stock on each of the following dates: December 9, 2014, September 10, 2014, June 11, 2014 and March 27, 2014.

The Company made quarterly installment payments on the Units of \$18.75 per Unit on December 1, 2016, September 1, 2016, March 1, 2016, December 1, 2015, September 1, 2015 and June 1, 2015, and of \$18.76 per Unit on June 1, 2016. In addition, the Company also made an installment payment on the Company's Units on March 2, 2015, which consisted of a quarterly installment payment of \$18.75 per Unit, plus a one-time incremental payment of \$1.25 per Unit for the period between November 25, 2014 and December 1, 2014, for a total payment of \$20.00 per Unit. To the extent that any Unit has been separated into its constituent Purchase Contract and its constituent share of Mandatory Redeemable Preferred Stock, the installment payment is payable only on the constituent share of Mandatory Redeemable Preferred Stock.

Equity compensation plans

In May 2011, the shareholders of the Company approved an additional three million shares of Common Stock issuable under the Company's incentive compensation plans to Company employees. In May 2014, the shareholders of the Company approved an additional 2.7 million shares of Common Stock issuable under the Company's incentive compensation plans to Company employees, and in February 2015, pursuant to an exception for shareholder approval under the exchange listing standards, the Company assumed an additional 1.4 million shares of Common Stock in connection with the Gentiva Merger, which shares are only issuable to legacy Gentiva employees or employees of the Company hired after February 2, 2015. In May 2012 and again in May 2015, the shareholders of the Company approved an additional 200,000 shares of Common Stock issuable under the Company's equity compensation plan to the Company's non-employee directors.

Plan descriptions

The Company maintains plans under which approximately eight million service-based restricted shares, performance-based restricted shares, service-based restricted stock units and options to purchase Common Stock may be granted to directors, officers and other key employees. Exercise provisions vary, but most stock options are exercisable in whole or in part beginning one to four years after grant and ending seven to ten years after grant. Shares of Common Stock available for future grants were 1,410,752, 3,262,892 and 3,000,183 at December 31, 2016, 2015 and 2014, respectively.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 17 – CAPITAL STOCK (Continued)

Stock options

In conjunction with the Gentiva Merger, 1,075,965 stock options were assumed in 2015. There were no other stock option grants during 2016, 2015, and 2014.

At December 31, 2016, unearned compensation costs related to non-vested stock options was immaterial. Compensation expense related to stock options approximated \$0.2 million (\$0.1 million net of income taxes) for the year ended December 31, 2016, \$0.4 million (\$0.3 million net of income taxes) for the year ended December 31, 2015 and was zero for the year ended December 31, 2014.

Activity in the various plans is summarized below:

	<u>Shares under option</u>	<u>Option price per share</u>	<u>Weighted average exercise price</u>
Balances, December 31, 2015	1,178,073	\$10.75 to \$27.79	\$ 23.29
Canceled	(123,992)	12.70 to 26.08	20.83
Balances, December 31, 2016	<u>1,054,081</u>	\$10.75 to \$27.79	\$ 23.58

No stock options were exercised during 2016. The intrinsic value of the stock options exercised during 2015 and 2014 approximated \$0.3 million and \$2.4 million, respectively. Cash received from stock option exercises in 2015 and 2014 totaled \$0.5 million and \$6.2 million, respectively.

A summary of stock options outstanding at December 31, 2016 follows:

<u>Range of exercise prices</u>	<u>Options outstanding</u>			<u>Options exercisable</u>	
	<u>Number outstanding at December 31, 2016</u>	<u>Weighted average remaining contractual life</u>	<u>Weighted average exercise price</u>	<u>Number exercisable at December 31, 2016</u>	<u>Weighted average exercise price</u>
\$10.75 to \$15.06	88,115	3 years	\$ 11.81	73,246	\$ 12.00
\$19.26 to \$19.81	214,285	0.2 year	19.33	214,285	19.33
\$25.27 to \$27.79	751,681	1 year	26.17	751,681	26.17
	<u>1,054,081</u>	1 year	\$ 23.58	<u>1,039,212</u>	\$ 23.76

The intrinsic value of the stock options outstanding and stock options that are exercisable as of December 31, 2016 was zero.

Service-based restricted shares

At December 31, 2016, unearned compensation costs related to non-vested service-based restricted shares aggregated \$11.5 million. These costs will be expensed over the remaining weighted average vesting period of approximately two years. Compensation expense related to these awards approximated \$14.2 million (\$8.6 million net of income taxes) for the year ended December 31, 2016, \$13.6 million (\$8.2 million net of income taxes) for the year ended December 31, 2015 and \$13.0 million (\$7.9 million net of income taxes) for the year ended December 31, 2014.

A summary of non-vested service-based restricted shares follows:

	<u>Non-vested service-based restricted shares</u>	<u>Weighted average fair value at date of grant</u>
Balances, December 31, 2015	1,244,737	\$ 19.84
Granted	1,567,818	11.61
Vested	(613,342)	18.18
Canceled	(183,589)	15.88
Balances, December 31, 2016	<u>2,015,624</u>	\$ 14.31

The fair value of restricted shares vested during 2016, 2015 and 2014 was \$6.9 million, \$22.7 million and \$15.0 million, respectively.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 17 – CAPITAL STOCK (Continued)

Performance-based restricted shares

Performance-based restricted share awards vest over a three-year period based upon the attainment of various performance measures in each performance period. Compensation expense related to these awards approximated \$1.0 million (\$0.6 million net of income taxes) for the year ended December 31, 2016, \$5.8 million (\$3.5 million net of income taxes) for the year ended December 31, 2015 and \$3.7 million (\$2.2 million net of income taxes) for the year ended December 31, 2014.

A summary of non-vested performance-based restricted shares follows:

	Non-vested performance-based restricted shares	Weighted average fair value at date of grant	
Balances, December 31, 2015	840,570		
Granted	677,015	\$	11.67
Vested	(242,992)		23.39
Canceled	(261,868)	\$	20.27
Balances, December 31, 2016	<u>1,012,725</u>		

The performance measures and fair value for each vesting period of a performance-based restricted share award are established annually. The performance measures and fair value for the non-vested performance-based restricted shares have not been established for vesting periods with performance measures determined after December 31, 2016.

Service-based restricted stock units

At December 31, 2016, unearned compensation related to non-vested service-based restricted stock units aggregated \$0.4 million. These costs will be expensed over the remaining weighted average vesting period of approximately one year. Compensation expense related to these awards approximated \$1.0 million (\$0.6 million net of income taxes) for the year ended December 31, 2016 and \$0.8 million (\$0.5 million net of income taxes) for the year ended December 31, 2015.

A summary of non-vested service-based restricted stock units follows:

	Non-vested service-based restricted stock units	Weighted average fair value at date of grant	
Balances, December 31, 2015	126,276	\$	18.22
Vested	(49,152)		18.22
Balances, December 31, 2016	<u>77,124</u>	\$	18.22

NOTE 18 – EMPLOYEE BENEFIT PLANS

The Company maintains defined contribution retirement plans covering employees who meet certain minimum eligibility requirements. Benefits are determined as a percentage of a participant's contributions and generally are vested based upon length of service. Retirement plan expense was \$5.1 million for 2016, \$8.6 million for 2015 and \$1.1 million for 2014. Amounts equal to retirement plan expense are funded annually.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 19 – ACCRUED LIABILITIES

A summary of other accrued liabilities at December 31 follows (in thousands):

	2016	2015
Patient accounts	\$ 74,780	\$ 60,530
Accrued interest	71,919	70,661
Taxes other than income	32,359	33,766
Accrued litigation contingency	18,757	150,895
Accrued room and board	15,888	16,954
Accrued hospice medical supplies and drugs	6,239	12,587
Ventas lease termination charge (current portion)	5,224	-
Other	44,570	48,853
	<u>\$ 269,736</u>	<u>\$ 394,246</u>

NOTE 20 – FINANCIAL INSTRUMENTS AND FAIR VALUE MEASUREMENTS

The Company follows the provisions of the authoritative guidance for fair value measurements, which addresses how companies should measure fair value when they are required to use a fair value measure for recognition or disclosure purposes under GAAP.

Fair value is defined as the exchange price that would be received for an asset or paid to transfer a liability in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. The guidance related to fair value measures establishes a fair value hierarchy that requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The guidance describes three levels of inputs that may be used to measure fair value:

- Level 1** Quoted prices in active markets for identical assets or liabilities. Level 1 assets and liabilities include debt and equity securities and derivative contracts that are traded in an active exchange market, as well as certain U.S. Treasury, other U.S. Government and agency asset backed debt securities that are highly liquid and are actively traded in over-the-counter markets.
- Level 2** Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, and other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.
- Level 3** Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities. Level 3 assets and liabilities include financial instruments whose value is determined using pricing models, discounted cash flow methodologies, or similar techniques, as well as instruments for which the determination of fair value requires significant management judgment or estimation.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 20 – FINANCIAL INSTRUMENTS AND FAIR VALUE MEASUREMENTS (Continued)

The Company's assets and liabilities measured at fair value on a recurring and non-recurring basis and any associated losses for the years ended December 31, 2016 and 2015 are summarized below (in thousands):

	Fair value measurements			Assets/liabilities at fair value	Total losses
	Level 1	Level 2	Level 3		
December 31, 2016					
Recurring:					
Assets:					
Available-for-sale debt securities:					
Corporate bonds	\$ -	\$ 55,176	\$ -	\$ 55,176	\$ -
U.S. Treasury notes	24,727	-	-	24,727	-
Debt securities issued by U.S. government agencies	-	18,288	-	18,288	-
	24,727	73,464	-	98,191	-
Available-for-sale equity securities	15,688	-	-	15,688	-
Money market funds	16,472	-	-	16,472	-
Certificates of deposit	-	14,864	-	14,864	-
Total available-for-sale investments	56,887	88,328	-	145,215	-
Deposits held in money market funds	100	4,126	-	4,226	-
	<u>\$ 56,987</u>	<u>\$ 92,454</u>	<u>\$ -</u>	<u>\$ 149,441</u>	<u>\$ -</u>
Liabilities:					
Contingent consideration liability	\$ -	\$ -	\$ (4,943)	\$ (4,943)	\$ -
Interest rate swaps	-	(2,718)	-	(2,718)	-
	<u>\$ -</u>	<u>\$ (2,718)</u>	<u>\$ (4,943)</u>	<u>\$ (7,661)</u>	<u>\$ -</u>
Non-recurring:					
Assets:					
Property and equipment	\$ -	\$ -	\$ 650,222	\$ 650,222	\$ (31,029)
Goodwill	-	-	361,310	361,310	(261,129)
Intangible assets - Hospitals	-	-	641	641	(3,559)
Intangible assets - Kindred at Home	-	-	19,010	19,010	(3,534)
Hospitals available for sale	-	-	-	-	(43,308)
	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 1,031,183</u>	<u>\$ 1,031,183</u>	<u>\$ (342,559)</u>
Liabilities					
	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>
December 31, 2015					
Recurring:					
Assets:					
Available-for-sale debt securities:					
Corporate bonds	\$ -	\$ 46,823	\$ -	\$ 46,823	\$ -
U.S. Treasury notes	33,331	-	-	33,331	-
Debt securities issued by U.S. government agencies	-	22,454	-	22,454	-
	33,331	69,277	-	102,608	-
Available-for-sale equity securities	14,251	-	-	14,251	-
Money market funds	31,429	-	-	31,429	-
Certificates of deposit	-	8,248	-	8,248	-
Total available-for-sale investments	79,011	77,525	-	156,536	-
Deposits held in money market funds	100	3,880	-	3,980	-
	<u>\$ 79,111</u>	<u>\$ 81,405</u>	<u>\$ -</u>	<u>\$ 160,516</u>	<u>\$ -</u>
Liabilities:					
Contingent consideration liability	\$ -	\$ -	\$ (6,437)	\$ (6,437)	\$ -
Interest rate swaps	-	(4,472)	-	(4,472)	-
	<u>\$ -</u>	<u>\$ (4,472)</u>	<u>\$ (6,437)</u>	<u>\$ (10,909)</u>	<u>\$ -</u>
Non-recurring:					
Assets:					
Intangible assets - trade names	\$ -	\$ -	\$ 98,774	\$ 98,774	\$ (24,757)
Liabilities					
	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 20 – FINANCIAL INSTRUMENTS AND FAIR VALUE MEASUREMENTS (Continued)

Recurring measurements

The Company's available-for-sale investments held by its limited purpose insurance subsidiary consist of debt securities, equities, money market funds and certificates of deposit. These available-for-sale investments and the insurance subsidiary's cash and cash equivalents of \$170.3 million as of December 31, 2016 and \$156.4 million as of December 31, 2015, classified as insurance subsidiary investments, are maintained for the payment of claims and expenses related to professional liability and workers compensation risks.

The Company also has available-for-sale investments totaling \$1.7 million as of December 31, 2016 and \$1.8 million as of December 31, 2015 related to a deferred compensation plan that is maintained for certain of the Company's current and former employees.

The fair value of actively traded debt and equity securities and money market funds are based upon quoted market prices and are generally classified as Level 1. The fair value of inactive traded debt securities and certificates of deposit are based upon either quoted market prices of similar securities or observable inputs such as interest rates using either a market or income valuation approach and are generally classified as Level 2. The Company's investment advisors obtain and review pricing for each security. The Company is responsible for the determination of fair value and as such the Company reviews the pricing information from its advisors in determining reasonable estimates of fair value. Based upon the Company's internal review procedures, there were no adjustments to the prices during 2016 or 2015.

The Company's deposits held in money market funds consist primarily of cash and cash equivalents for the Company's insurance programs and for general corporate purposes.

The Company acquired a contingent consideration liability in the Gentiva Merger from a prior acquisition by Gentiva with an initial estimated fair value of \$7.9 million. The fair value is determined using a discounted cash flow approach utilizing Level 2 and Level 3 inputs which includes observable market discount rates, fixed payment schedules, and assumptions based on achieving certain predefined performance criteria. As of December 31, 2016, the fair value of the Level 2 and 3 contingent consideration liability was \$4.9 million. The change in fair value for the year ended December 31, 2016 consists of \$1.8 million in payments and \$0.3 million in accrued interest included in interest expense in the accompanying consolidated statement of operations. A one percent change in the discount rate used to calculate the accretion of the present value of the contingent consideration liability would have an impact on the fair value of approximately \$0.1 million.

The fair value of the derivative liability associated with the interest rate swaps is estimated using industry-standard valuation models, which are Level 2 measurements. Such models project future cash flows and discount the future amounts to a present value using market-based observable inputs, including interest rate curves. See Note 14.

The following table presents the carrying amounts and estimated fair values of the Company's financial instruments. The carrying value is equal to fair value for financial instruments that are based upon quoted market prices or current market rates. The Company's long-term debt is based upon Level 2 inputs.

(In thousands)	December 31, 2016		December 31, 2015	
	Carrying value	Fair value	Carrying value	Fair value
Cash and cash equivalents	\$ 137,061	\$ 137,061	\$ 98,758	\$ 98,758
Insurance subsidiary investments	313,895	313,895	311,136	311,136
Long-term debt, including amounts due within one year (excluding capital lease obligations totaling \$0.6 million and \$0.8 million at December 31, 2016 and December 31, 2015, respectively)	3,242,459	3,220,291	3,110,130	2,978,890

Non-recurring measurements

During the fourth quarter of 2016, the Company recorded an asset impairment charge of \$3.6 million related to previously acquired home health and hospice Medicare certifications, certificates of need and a trade name, as part of the annual indefinite-lived intangible assets review at October 1, 2016. These charges reflect the amount by which the carrying value exceeded its estimated fair value. The fair values of the assets were measured using Level 3 unobservable inputs, such as projected revenue and operating cash flows.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 20 – FINANCIAL INSTRUMENTS AND FAIR VALUE MEASUREMENTS (Continued)

Non-recurring measurements (Continued)

During the year ended December 31, 2016, the Company recorded a goodwill impairment charge of \$261.1 million and a property and equipment impairment charge of \$3.2 million related to the Hospital Division Triggering Event. These charges reflect the amounts by which the carrying value of the assets exceeded their estimated fair value. The fair value of the assets was measured using Level 3 inputs such as operating cash flows, market data and replacement cost factoring in depreciation, economic obsolescence and inflation trends.

During the year ended December 31, 2016, the Company recorded impairment charges aggregating \$33.0 million, comprised of \$19.7 million related to property and equipment, and \$13.3 million related to goodwill and other intangible assets related to the Curahealth Disposal. These charges reflect the amounts by which the carrying value of the assets exceeded their estimated fair value. The fair value of the assets was measured using a Level 3 input of the offer pending from Curahealth at September 30, 2016. The properties were subsequently sold during the fourth quarter of 2016. In addition, during the first quarter of 2016, the Company recorded asset impairment charges of \$7.8 million under the held and used accounting model related to the planned Curahealth Disposal. These charges reflect the amount by which the carrying value of certain property and equipment exceeded its estimated fair value. The fair value of property and equipment was measured in the first quarter of 2016 using Level 3 inputs, primarily replacement costs.

During the year ended December 31, 2016, the Company reviewed the long-lived assets related to the decline in financial performance of its nursing center division. After determining it was more likely than not that the Company would dispose of its skilled nursing facility business, the Company determined that its property and equipment was impaired. As a result, the Company recorded an impairment charge of \$22.5 million. The fair value of the assets was measured using Level 3 inputs, such as operating cash flows and replacement costs.

During the year ended December 31, 2016, the Company reviewed the long-lived assets related to the planned divestiture and pending offers for a nursing center held for sale and determined its property and equipment was impaired. As a result, the Company recorded an impairment charge of \$5.3 million. The fair value of the assets was measured based upon pending offers, a Level 3 input.

During the year ended December 31, 2016, the Company recorded an asset impairment charge of \$2.6 million related to the sale of a hospital medical office building. This charge reflects the amount by which the carrying value of the property exceeded its estimated fair value. The fair value of the property was measured using a Level 3 input of the offer pending at June 30, 2016. The property was subsequently sold during the third quarter of 2016.

During the year ended December 31, 2016, the Company also recorded an impairment charge of \$3.5 million related to certificates of need for two hospitals as part of the annual indefinite-lived intangible assets impairment review at May 1, 2016. This charge reflects the amount by which the carrying value of the certificates of need exceeded its estimated fair value. The fair value of the certificates of need was measured using Level 3 inputs, such as operating cash flows.

During the fourth quarter of 2015, the Company recorded an asset impairment charge of \$18.0 million related to the previously acquired RehabCare trade name due to the cancellation of contracts associated with one large customer in the fourth quarter of 2015 and a reduction in projected revenues in 2016. The charge reflects the amount by which the carrying value exceeded its estimated fair value. The fair value of the trade name was measured using Level 3 inputs such as projected revenues and the industry specific royalty rate.

During the year ended December 31, 2015, the Company recorded an asset impairment charge of \$6.7 million related to previously acquired home health and hospice trade names after the decision in the first quarter of 2015 to rebrand to the Kindred at Home trade name. These charges reflect the amount by which the carrying value exceeded its estimated fair value. The fair value of the trade names was measured using Level 3 unobservable inputs, primarily economic obsolescence.

NOTE 21 – NONCONTROLLING INTERESTS

As of December 31, 2016, the Company had ownership ranging from 40% to 99% in various partnerships. During 2016, the Company completed a full joint venture buyout of a noncontrolling interest. In accordance with the authoritative guidance of noncontrolling interests, this payment has been accounted for as an equity transaction. During 2015 and 2014, the Company did not complete any buyouts of noncontrolling interests.

Decrease in carrying value of noncontrolling interests for purchase of noncontrolling interest in subsidiary	\$ 766
Decrease in Company's capital in excess of par value for purchase of noncontrolling interest in subsidiary	234
Total cash consideration paid in exchange for purchase of noncontrolling interest	<u>\$ 1,000</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 22 – CONDENSED CONSOLIDATING FINANCIAL INFORMATION

The accompanying condensed consolidating financial information has been prepared and presented pursuant to SEC Regulation S-X, Rule 3-10, “Financial Statements of Guarantors and Issuers of Guaranteed Securities Registered or Being Registered.” The Company’s Notes due 2020, Notes due 2022 and Notes due 2023 are fully and unconditionally guaranteed by substantially all of the Company’s domestic 100% owned subsidiaries. The Company’s Notes due 2020 and the Notes due 2023, which were issued during 2014, were senior unsecured obligations of the Escrow Issuer, which, prior to the Gentiva Merger, was a non-guarantor subsidiary of the Company. In connection with the Gentiva Merger, the Escrow Issuer was merged with and into the Company, with the Company assuming the Notes due 2020 and Notes due 2023. See Note 14. The equity method has been used with respect to the parent company’s investment in subsidiaries.

The following condensed consolidating financial data present the financial position of the parent company/issuer, the guarantor subsidiaries and the non-guarantor subsidiaries as of December 31, 2016 and December 31, 2015, and the respective results of operations and cash flows for the three years ended December 31, 2016.

Condensed Consolidating Statement of Operations and Comprehensive Income (Loss)

(In thousands)	Year ended December 31, 2016				
	Parent company/ issuer	Guarantor subsidiaries	Non-guarantor subsidiaries	Consolidating and eliminating adjustments	Consolidated
Revenues	\$ -	\$ 6,284,655	\$ 1,036,979	\$ (102,115)	\$ 7,219,519
Salaries, wages and benefits	-	3,511,750	246,673	-	3,758,423
Supplies	-	331,865	52,233	-	384,098
Rent	-	307,296	83,238	-	390,534
Other operating expenses	-	737,991	107,689	-	845,680
General and administrative expenses	-	1,006,794	398,749	(102,115)	1,303,428
Other (income) expense	-	75	(2,975)	-	(2,900)
Litigation contingency expense	-	2,840	-	-	2,840
Impairment charges	-	220,887	121,672	-	342,559
Restructuring charges	-	105,157	2,018	-	107,175
Depreciation and amortization	-	148,708	10,694	-	159,402
Management fees	-	(8,862)	8,862	-	-
Intercompany interest (income) expense from affiliates	(222,445)	177,535	44,910	-	-
Interest expense (income)	234,630	(94)	111	-	234,647
Investment income	-	(490)	(2,672)	-	(3,162)
Equity in net loss of consolidating affiliates	656,019	-	-	(656,019)	-
	<u>668,204</u>	<u>6,541,452</u>	<u>1,071,202</u>	<u>(758,134)</u>	<u>7,522,724</u>
Loss from continuing operations before income taxes	(668,204)	(256,797)	(34,223)	656,019	(303,205)
Provision (benefit) for income taxes	(3,974)	308,768	9,536	-	314,330
Loss from continuing operations	(664,230)	(565,565)	(43,759)	656,019	(617,535)
Discontinued operations, net of income taxes:					
Income from operations	-	6,452	164	-	6,616
Gain on divestiture of operations	-	295	-	-	295
Income from discontinued operations	-	6,747	164	-	6,911
Net loss	(664,230)	(558,818)	(43,595)	656,019	(610,624)
Earnings attributable to noncontrolling interests:					
Continuing operations	-	-	(53,602)	-	(53,602)
Discontinued operations	-	-	(4)	-	(4)
	-	-	(53,606)	-	(53,606)
Loss attributable to Kindred	<u>\$ (664,230)</u>	<u>\$ (558,818)</u>	<u>\$ (97,201)</u>	<u>\$ 656,019</u>	<u>\$ (664,230)</u>
Comprehensive loss	<u>\$ (660,025)</u>	<u>\$ (558,598)</u>	<u>\$ (43,255)</u>	<u>\$ 655,459</u>	<u>\$ (606,419)</u>
Comprehensive loss attributable to Kindred	<u>\$ (660,025)</u>	<u>\$ (558,598)</u>	<u>\$ (96,861)</u>	<u>\$ 655,459</u>	<u>\$ (660,025)</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 22 – CONDENSED CONSOLIDATING FINANCIAL INFORMATION (Continued)

Condensed Consolidating Statement of Operations and Comprehensive Loss (Continued)

(In thousands)	Year ended December 31, 2015				
	Parent company/ issuer	Guarantor subsidiaries	Non-guarantor subsidiaries	Consolidating and eliminating adjustments	Consolidated
Revenues	\$ -	\$ 6,185,250	\$ 972,531	\$ (102,874)	\$ 7,054,907
Salaries, wages and benefits	-	3,384,596	229,495	-	3,614,091
Supplies	-	333,358	50,996	-	384,354
Rent	-	303,355	76,534	-	379,889
Other operating expenses	-	726,135	99,861	-	825,996
General and administrative expenses	-	1,099,107	388,805	(102,874)	1,385,038
Other (income) expense	-	86	(3,102)	-	(3,016)
Litigation contingency expense	-	138,648	-	-	138,648
Impairment charges	-	24,757	-	-	24,757
Restructuring charges	-	12,970	-	-	12,970
Depreciation and amortization	-	147,308	9,943	-	157,251
Management fees	-	(19,904)	19,904	-	-
Intercompany interest (income) expense from affiliates	(205,411)	160,172	45,239	-	-
Interest expense	228,826	3,220	349	-	232,395
Investment income	-	(1,650)	(1,156)	-	(2,806)
Equity in net loss of consolidating affiliates	79,183	-	-	(79,183)	-
	<u>102,598</u>	<u>6,312,158</u>	<u>916,868</u>	<u>(182,057)</u>	<u>7,149,567</u>
Income (loss) from continuing operations before income taxes	(102,598)	(126,908)	55,663	79,183	(94,660)
Provision (benefit) for income taxes	(9,214)	(41,167)	7,584	-	(42,797)
Income (loss) from continuing operations	(93,384)	(85,741)	48,079	79,183	(51,863)
Discontinued operations, net of income taxes:					
Income (loss) from operations	-	755	(990)	-	(235)
Gain on divestiture of operations	-	1,244	-	-	1,244
Income (loss) from discontinued operations	-	1,999	(990)	-	1,009
Net income (loss)	(93,384)	(83,742)	47,089	79,183	(50,854)
(Earnings) loss attributable to noncontrolling interests:					
Continuing operations	-	-	(42,564)	-	(42,564)
Discontinued operations	-	-	34	-	34
	-	-	(42,530)	-	(42,530)
Income (loss) attributable to Kindred	<u>\$ (93,384)</u>	<u>\$ (83,742)</u>	<u>\$ 4,559</u>	<u>\$ 79,183</u>	<u>\$ (93,384)</u>
Comprehensive income (loss)	<u>\$ (93,465)</u>	<u>\$ (83,286)</u>	<u>\$ 46,890</u>	<u>\$ 78,926</u>	<u>\$ (50,935)</u>
Comprehensive income (loss) attributable to Kindred	<u>\$ (93,465)</u>	<u>\$ (83,286)</u>	<u>\$ 4,360</u>	<u>\$ 78,926</u>	<u>\$ (93,465)</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 22 – CONDENSED CONSOLIDATING FINANCIAL INFORMATION (Continued)

Condensed Consolidating Statement of Operations and Comprehensive Loss (Continued)

(In thousands)	Year ended December 31, 2014				
	Parent company/ issuer	Guarantor subsidiaries	Non-guarantor subsidiaries	Consolidating and eliminating adjustments	Consolidated
Revenues	\$ -	\$ 4,466,335	\$ 664,504	\$ (103,240)	\$ 5,027,599
Salaries, wages and benefits	-	2,309,844	133,035	-	2,442,879
Supplies	-	257,066	31,977	-	289,043
Rent	-	263,536	49,256	-	312,792
Other operating expenses	-	594,596	85,396	-	679,992
General and administrative expenses	-	779,056	293,219	(103,240)	969,035
Other (income) expense	-	233	(1,105)	-	(872)
Litigation contingency expense	-	4,600	-	-	4,600
Restructuring charges	-	4,435	-	-	4,435
Depreciation and amortization	-	146,994	8,576	-	155,570
Management fees	-	(13,256)	13,256	-	-
Intercompany interest (income) expense from affiliates	(117,330)	80,093	37,237	-	-
Interest expense	164,229	15	4,519	-	168,763
Investment income	-	(587)	(3,409)	-	(3,996)
Equity in net loss of consolidating affiliates	51,393	-	-	(51,393)	-
	<u>98,292</u>	<u>4,426,625</u>	<u>651,957</u>	<u>(154,633)</u>	<u>5,022,241</u>
Income (loss) from continuing operations before income taxes	(98,292)	39,710	12,547	51,393	5,358
Provision (benefit) for income taxes	(18,455)	13,086	5,831	-	462
Income (loss) from continuing operations	(79,837)	26,624	6,716	51,393	4,896
Discontinued operations, net of income taxes:					
Loss from operations	-	(47,647)	(5,983)	-	(53,630)
Loss on divestiture of operations	-	(10,572)	(2,126)	-	(12,698)
Loss from discontinued operations	-	(58,219)	(8,109)	-	(66,328)
Net loss	(79,837)	(31,595)	(1,393)	51,393	(61,432)
(Earnings) loss attributable to noncontrolling interests:					
Continuing operations	-	-	(18,872)	-	(18,872)
Discontinued operations	-	-	467	-	467
	-	-	(18,405)	-	(18,405)
Loss attributable to Kindred	<u>\$ (79,837)</u>	<u>\$ (31,595)</u>	<u>\$ (19,798)</u>	<u>\$ 51,393</u>	<u>\$ (79,837)</u>
Comprehensive loss	<u>\$ (82,136)</u>	<u>\$ (32,701)</u>	<u>\$ (2,560)</u>	<u>\$ 53,666</u>	<u>\$ (63,731)</u>
Comprehensive loss attributable to Kindred	<u>\$ (82,136)</u>	<u>\$ (32,701)</u>	<u>\$ (20,965)</u>	<u>\$ 53,666</u>	<u>\$ (82,136)</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 22 – CONDENSED CONSOLIDATING FINANCIAL INFORMATION (Continued)

Condensed Consolidating Balance Sheet

	As of December 31, 2016				
(In thousands)	Parent company/ issuer	Guarantor subsidiaries	Non-guarantor subsidiaries	Consolidating and eliminating adjustments	Consolidated
ASSETS					
Current assets:					
Cash and cash equivalents	\$ -	\$ 25,767	\$ 111,294	\$ -	\$ 137,061
Insurance subsidiary investments	-	-	108,966	-	108,966
Accounts receivable, net	-	1,022,850	149,228	-	1,172,078
Inventories	-	19,990	4,683	-	24,673
Income taxes	-	9,023	1,044	-	10,067
Other	-	56,054	7,639	-	63,693
	<u>-</u>	<u>1,133,684</u>	<u>382,854</u>	<u>-</u>	<u>1,516,538</u>
Property and equipment, net	-	807,501	71,085	-	878,586
Goodwill	-	1,977,003	450,071	-	2,427,074
Intangible assets, net	-	743,887	46,348	-	790,235
Insurance subsidiary investments	-	-	204,929	-	204,929
Intercompany	4,850,517	-	-	(4,850,517)	-
Deferred tax assets	-	-	7,224	(7,224)	-
Other	10,123	123,427	161,812	-	295,362
	<u>\$ 4,860,640</u>	<u>\$ 4,785,502</u>	<u>\$ 1,324,323</u>	<u>\$ (4,857,741)</u>	<u>\$ 6,112,724</u>
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	\$ -	\$ 112,286	\$ 91,639	\$ -	\$ 203,925
Salaries, wages and other compensation	-	339,600	57,886	-	397,486
Due to third party payors	-	41,320	-	-	41,320
Professional liability risks	-	3,401	61,883	-	65,284
Other accrued liabilities	74,634	175,700	19,402	-	269,736
Long-term debt due within one year	26,406	-	1,571	-	27,977
	<u>101,040</u>	<u>672,307</u>	<u>232,381</u>	<u>-</u>	<u>1,005,728</u>
Long-term debt	3,214,607	-	455	-	3,215,062
Intercompany/deficiency in earnings of consolidated subsidiaries	732,442	4,281,685	568,832	(5,582,959)	-
Professional liability risks	-	78,124	217,187	-	295,311
Deferred tax liabilities	-	209,032	-	(7,224)	201,808
Deferred credits and other liabilities	-	219,701	133,593	-	353,294
Commitments and contingencies					
Equity (deficit):					
Stockholder's equity (deficit)	812,551	(675,347)	(57,095)	732,442	812,551
Noncontrolling interests	-	-	228,970	-	228,970
	<u>812,551</u>	<u>(675,347)</u>	<u>171,875</u>	<u>732,442</u>	<u>1,041,521</u>
	<u>\$ 4,860,640</u>	<u>\$ 4,785,502</u>	<u>\$ 1,324,323</u>	<u>\$ (4,857,741)</u>	<u>\$ 6,112,724</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 22 – CONDENSED CONSOLIDATING FINANCIAL INFORMATION (Continued)

Condensed Consolidating Balance Sheet (Continued)

As of December 31, 2015					
(In thousands)	Parent company/ issuer	Guarantor subsidiaries	Non-guarantor subsidiaries	Consolidating and eliminating adjustments	Consolidated
ASSETS					
Current assets:					
Cash and cash equivalents	\$ -	\$ 18,232	\$ 80,526	\$ -	\$ 98,758
Insurance subsidiary investments	-	-	106,638	-	106,638
Accounts receivable, net	-	1,039,761	155,107	-	1,194,868
Inventories	-	23,125	4,666	-	27,791
Income taxes	-	10,913	877	-	11,790
Other	-	53,648	7,406	-	61,054
	-	1,145,679	355,220	-	1,500,899
Property and equipment, net	-	911,611	60,385	-	971,996
Goodwill	-	2,098,812	570,998	-	2,669,810
Intangible assets, net	-	707,792	47,863	-	755,655
Insurance subsidiary investments	-	-	204,498	-	204,498
Intercompany	4,749,257	-	-	(4,749,257)	-
Deferred tax assets	-	95,721	8,409	-	104,130
Acquisition deposit	-	18,489	-	-	18,489
Other	11,312	116,692	114,778	-	242,782
	<u>\$ 4,760,569</u>	<u>\$ 5,094,796</u>	<u>\$ 1,362,151</u>	<u>\$ (4,749,257)</u>	<u>\$ 6,468,259</u>
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	\$ -	\$ 106,253	\$ 80,808	\$ -	\$ 187,061
Salaries, wages and other compensation	-	348,548	56,377	-	404,925
Due to third party payors	-	36,251	-	-	36,251
Professional liability risks	-	4,813	59,286	-	64,099
Other accrued liabilities	75,134	297,608	21,504	-	394,246
Long-term debt due within one year	23,524	-	1,106	-	24,630
	98,658	793,473	219,081	-	1,111,212
Long-term debt	3,085,074	-	1,274	-	3,086,348
Intercompany/deficiency in earnings of consolidated subsidiaries	76,983	4,142,653	606,604	(4,826,240)	-
Professional liability risks	-	61,472	201,801	-	263,273
Deferred credits and other liabilities	-	175,173	126,206	-	301,379
Commitments and contingencies					
Equity (deficit):					
Stockholder's equity (deficit)	1,499,854	(77,975)	992	76,983	1,499,854
Noncontrolling interests	-	-	206,193	-	206,193
	<u>1,499,854</u>	<u>(77,975)</u>	<u>207,185</u>	<u>76,983</u>	<u>1,706,047</u>
	<u>\$ 4,760,569</u>	<u>\$ 5,094,796</u>	<u>\$ 1,362,151</u>	<u>\$ (4,749,257)</u>	<u>\$ 6,468,259</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 22 – CONDENSED CONSOLIDATING FINANCIAL INFORMATION (Continued)

Condensed Consolidating Statement of Cash Flows

(In thousands)	Year ended December 31, 2016				
	Parent company/ issuer	Guarantor subsidiaries	Non-guarantor subsidiaries	Consolidating and eliminating adjustments	Consolidated
Net cash provided by (used in) operating activities	\$ (5,302)	\$ 95,039	\$ 95,225	\$ -	\$ 184,962
Cash flows from investing activities:					
Routine capital expenditures	-	(88,875)	(7,177)	-	(96,052)
Development capital expenditures	-	(14,060)	(20,765)	-	(34,825)
Acquisitions, net of cash acquired	-	(78,840)	-	-	(78,840)
Acquisition deposits	-	18,489	-	-	18,489
Sale of assets	-	25,987	-	-	25,987
Purchase of insurance subsidiary investments	-	-	(97,740)	-	(97,740)
Sale of insurance subsidiary investments	-	-	95,488	-	95,488
Net change in insurance subsidiary cash and cash equivalents	-	-	877	-	877
Net change in other investments	-	(34,521)	1,751	-	(32,770)
Other	-	(255)	-	-	(255)
Net cash used in investing activities	-	(172,075)	(27,566)	-	(199,641)
Cash flows from financing activities:					
Proceeds from borrowings under revolving credit	1,643,300	-	-	-	1,643,300
Repayment of borrowings under revolving credit	(1,689,400)	-	-	-	(1,689,400)
Proceeds from issuance of term loan, net of discount	198,100	-	-	-	198,100
Proceeds from other long-term debt	-	-	750	-	750
Repayment of term loan	(13,527)	-	-	-	(13,527)
Repayment of other long-term debt	-	-	(1,104)	-	(1,104)
Payment of deferred financing costs	(522)	-	-	-	(522)
Payment of dividend for Mandatory Redeemable Preferred Stock	(11,514)	-	-	-	(11,514)
Dividends paid	(40,738)	-	-	-	(40,738)
Contributions made by noncontrolling interests	-	-	14,514	-	14,514
Distributions to noncontrolling interests	-	-	(45,985)	-	(45,985)
Purchase of noncontrolling interests	-	-	(1,000)	-	(1,000)
Other	-	108	-	-	108
Net change in intercompany accounts	(80,397)	84,463	(4,066)	-	-
Net cash provided by (used in) financing activities	5,302	84,571	(36,891)	-	52,982
Change in cash and cash equivalents	-	7,535	30,768	-	38,303
Cash and cash equivalents at beginning of period	-	18,232	80,526	-	98,758
Cash and cash equivalents at end of period	\$ -	\$ 25,767	\$ 111,294	\$ -	\$ 137,061

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 22 – CONDENSED CONSOLIDATING FINANCIAL INFORMATION (Continued)

Condensed Consolidating Statement of Cash Flows (Continued)

(In thousands)	Year ended December 31, 2015				
	Parent company/ issuer	Guarantor subsidiaries	Non-guarantor subsidiaries	Consolidating and eliminating adjustments	Consolidated
Net cash provided by operating activities	\$ 21,963	\$ 71,617	\$ 69,682	\$ -	\$ 163,262
Cash flows from investing activities:					
Routine capital expenditures	-	(110,776)	(11,155)	-	(121,931)
Development capital expenditures	-	(19,931)	-	-	(19,931)
Acquisitions, net of cash acquired	-	(511,683)	(161,864)	-	(673,547)
Acquisition deposits	-	176,511	-	-	176,511
Sale of assets	-	8,735	-	-	8,735
Proceeds from senior unsecured notes offering held in escrow	-	-	1,350,000	-	1,350,000
Interest in escrow for senior unsecured notes	-	-	23,438	-	23,438
Purchase of insurance subsidiary investments	-	-	(85,222)	-	(85,222)
Sale of insurance subsidiary investments	-	-	75,075	-	75,075
Net change in insurance subsidiary cash and cash equivalents	-	-	(12,271)	-	(12,271)
Proceeds from note receivable	-	25,000	-	-	25,000
Net change in other investments	-	(4,620)	-	-	(4,620)
Other	-	10,972	-	-	10,972
Net cash provided by (used in) investing activities	-	(425,792)	1,178,001	-	752,209
Cash flows from financing activities:					
Proceeds from borrowings under revolving credit	1,740,450	-	-	-	1,740,450
Repayment of borrowings under revolving credit	(1,631,850)	-	-	-	(1,631,850)
Proceeds from issuance of senior unsecured notes due 2020 and 2023	1,350,000	-	(1,350,000)	-	-
Proceeds from issuance of term loan, net of discount	199,000	-	-	-	199,000
Repayment of Gentiva debt	-	(1,177,363)	-	-	(1,177,363)
Repayment of term loan	(12,010)	-	-	-	(12,010)
Repayment of other long-term debt	-	-	(6,752)	-	(6,752)
Payment of deferred financing costs	(3,446)	-	-	-	(3,446)
Issuance of Common Stock in connection with employee benefit plans	534	-	-	-	534
Payment of costs associated with issuance of common stock and tangible equity units	(915)	-	-	-	(915)
Payment of dividend for Mandatory Redeemable Preferred Stock	(10,887)	-	-	-	(10,887)
Dividends paid	(40,119)	-	-	-	(40,119)
Contributions made by noncontrolling interests	-	-	2,152	-	2,152
Distributions to noncontrolling interests	-	-	(42,458)	-	(42,458)
Change in intercompany accounts	(1,612,720)	1,417,599	195,121	-	-
Other	-	2,763	-	-	2,763
Net cash provided by (used in) financing activities	(21,963)	242,999	(1,201,937)	-	(980,901)
Change in cash and cash equivalents	-	(111,176)	45,746	-	(65,430)
Cash and cash equivalents at beginning of period	-	129,408	34,780	-	164,188
Cash and cash equivalents at end of period	\$ -	\$ 18,232	\$ 80,526	\$ -	\$ 98,758

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 22 – CONDENSED CONSOLIDATING FINANCIAL INFORMATION (Continued)

Condensed Consolidating Statement of Cash Flows (Continued)

	Year ended December 31, 2014				
(In thousands)	Parent company/ issuer	Guarantor subsidiaries	Non-guarantor subsidiaries	Consolidating and eliminating adjustments	Consolidated
Net cash provided by (used in) operating activities	\$ (26,637)	\$ 91,605	\$ 40,503	\$ -	\$ 105,471
Cash flows from investing activities:					
Routine capital expenditures	-	(85,983)	(5,098)	-	(91,081)
Development capital expenditures	-	(5,257)	-	-	(5,257)
Acquisitions, net of cash acquired	-	(23,986)	(150)	-	(24,136)
Acquisition deposits	-	(195,000)	-	-	(195,000)
Sale of assets	-	23,861	-	-	23,861
Proceeds from senior unsecured notes offering held in escrow	-	-	(1,350,000)	-	(1,350,000)
Interest in escrow for senior unsecured notes	-	-	(23,438)	-	(23,438)
Purchase of insurance subsidiary investments	-	-	(105,324)	-	(105,324)
Sale of insurance subsidiary investments	-	-	51,716	-	51,716
Net change in insurance subsidiary cash and cash equivalents	-	-	33,683	-	33,683
Net change in other investments	-	1,406	-	-	1,406
Other	-	679	-	-	679
Net cash used in investing activities	-	(284,280)	(1,398,611)	-	(1,682,891)
Cash flows from financing activities:					
Proceeds from borrowings under revolving credit	1,551,515	-	-	-	1,551,515
Repayment of borrowings under revolving credit	(1,807,615)	-	-	-	(1,807,615)
Proceeds from issuance of term loan, net of discount	997,500	-	-	-	997,500
Proceeds from issuance of senior unsecured notes due 2022	500,000	-	-	-	500,000
Proceeds from issuance of senior unsecured notes due 2020 and 2023	-	-	1,350,000	-	1,350,000
Proceeds from issuance of debt component of tangible equity units	34,773	-	-	-	34,773
Repayment of senior unsecured notes	(550,000)	-	-	-	(550,000)
Repayment of term loan	(788,563)	-	-	-	(788,563)
Repayment of other long-term debt	-	(35)	(238)	-	(273)
Payment of deferred financing costs	(3,431)	-	-	-	(3,431)
Equity offering, net of offering costs	321,968	-	-	-	321,968
Issuance of equity component of tangible equity units, net of issuance costs	133,336	-	-	-	133,336
Issuance of Common Stock in connection with employee benefit plans	6,243	-	-	-	6,243
Dividends paid	(28,594)	-	-	-	(28,594)
Distributions to noncontrolling interests	-	-	(13,692)	-	(13,692)
Change in intercompany accounts	(340,495)	296,114	44,381	-	-
Other	-	2,469	-	-	2,469
Net cash provided by financing activities	26,637	298,548	1,380,451	-	1,705,636
Change in cash and cash equivalents	-	105,873	22,343	-	128,216
Cash and cash equivalents at beginning of period	-	23,535	12,437	-	35,972
Cash and cash equivalents at end of period	\$ -	\$ 129,408	\$ 34,780	\$ -	\$ 164,188

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 23 – LEGAL AND REGULATORY PROCEEDINGS

The Company provides services in a highly regulated industry and is subject to various legal actions and regulatory and other governmental and internal audits and investigations in the ordinary course of business (including investigations resulting from the Company's obligation to self-report suspected violations of law). These matters could (1) require the Company to pay substantial damages, fines, penalties or amounts in judgments or settlements, which individually or in the aggregate could exceed amounts, if any, that may be recovered under the Company's insurance policies where coverage applies and is available; (2) cause the Company to incur substantial expenses; (3) require significant time and attention from the Company's management; (4) subject the Company to sanctions, including possible exclusions from the Medicare and Medicaid programs; and (5) cause the Company to close or sell one or more facilities or otherwise modify the way the Company conducts business. The ultimate resolution of these matters, whether as a result of litigation or settlement, could have a material adverse effect on the Company's business, financial position, results of operations, and liquidity.

In accordance with authoritative accounting guidance related to loss contingencies, the Company records an accrued liability for litigation and regulatory matters that are both probable and reasonably estimable. Additional losses in excess of amounts accrued may be reasonably possible. The Company reviews loss contingencies that are reasonably possible and determines whether an estimate of the possible loss or range of loss, individually or in aggregate, can be disclosed in the Company's consolidated financial statements. These estimates are based upon currently available information for those legal and regulatory proceedings in which the Company is involved, taking into account the Company's best estimate of losses for those matters for which such estimate can be made. The Company's estimates involve significant judgment and a variety of assumptions, given that (1) these legal and regulatory proceedings may be in early stages; (2) discovery may not be completed; (3) damages sought in these legal and regulatory proceedings can be unsubstantiated or indeterminate; (4) the matters often involve legal uncertainties or evolving areas of law; (5) there are often significant facts in dispute; and/or (6) there is a wide range of possible outcomes. Accordingly, the Company's estimated loss or range of loss may change from time to time, and actual losses may be more or less than the current estimate. At this time, except as otherwise specifically noted, no estimate of the possible loss or range of loss, individually or in the aggregate, in excess of the amounts accrued, if any, can be made regarding the matters described below.

Set forth below are descriptions of the Company's significant legal proceedings.

Medicare and Medicaid payment reviews, audits, and investigations—As a result of the Company's participation in the Medicare and Medicaid programs, the Company faces and is currently subject to various governmental and internal reviews, audits, and investigations to verify the Company's compliance with these programs and applicable laws and regulations. The Company is routinely subject to audits under various government programs, such as the CMS Recovery Audit Contractor program, in which third party firms engaged by CMS conduct extensive reviews of claims data and medical and other records to identify potential improper payments to healthcare providers under the Medicare program. In addition, the Company, like other healthcare providers, is subject to ongoing investigations by the OIG, the DOJ and state attorneys general into the billing of services provided to Medicare and Medicaid patients, including whether such services were properly documented and billed, whether services provided were medically necessary, and general compliance with conditions of participation in the Medicare and Medicaid programs. Private pay sources such as third party insurance and managed care entities also often reserve the right to conduct audits. The Company's costs to respond to and defend any such reviews, audits, and investigations are significant and are likely to increase in the current enforcement environment. These audits and investigations may require the Company to refund or retroactively adjust amounts that have been paid under the relevant government program or by other payors. Further, an adverse review, audit, or investigation also could result in other adverse consequences, particularly if the underlying conduct is found to be pervasive or systemic. These consequences include (1) state or federal agencies imposing fines, penalties, and other sanctions on the Company; (2) loss of the Company's right to participate in the Medicare or Medicaid programs or one or more third party payor networks; (3) indemnity claims asserted by customers and others for which the Company provides services; and (4) damage to the Company's reputation in various markets, which could adversely affect the Company's ability to attract patients, residents and employees.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 23 – LEGAL AND REGULATORY PROCEEDINGS (Continued)

On January 12, 2016, the Company entered into a settlement agreement (the “Settlement Agreement”) with the United States of America, acting through the DOJ and on behalf of the OIG (the “United States”), to resolve the pending DOJ investigation concerning the operations of RehabCare, a therapy services company the Company acquired on June 1, 2011. Under the Settlement Agreement, the Company paid \$125 million, plus accrued interest from August 31, 2015, at the rate of 1.875% per annum to the United States during the first quarter of 2016. In the first quarter of 2015, the Company recorded a \$95 million loss reserve for this matter and disclosed an estimated settlement range of \$95 million to \$125 million. Based on the progress of continuing settlement discussions through October 2015, the Company recorded an additional \$30 million loss provision in the third quarter of 2015. The Company recorded an additional loss reserve of approximately \$2 million in the fourth quarter of 2015 related to the Settlement Agreement and associated costs and, in connection with establishing the final terms of the Settlement Agreement, also recorded an income tax benefit of \$47 million in the fourth quarter of 2015. In connection with the resolution of this matter, and in exchange for the OIG’s agreement not to exclude the Company or its subsidiaries from participating in the federal healthcare programs, on January 11, 2016, the Company entered into the RehabCare CIA.

In connection with the Settlement Agreement, RehabCare has received requests for indemnification from some of its current and former customers related to alleged damages stemming from payments made by these customers to the DOJ and the related legal and other costs. As of December 31, 2016, the Company has recorded an estimated aggregate loss contingency reserve of approximately \$5.8 million for these matters. No estimate of the possible loss in excess of the amount accrued can be made regarding these matters at this time. There is no certainty about the timing or likelihood of any definitive resolutions relating to these indemnification claims. The Company disputes the allegations in these indemnification claims and will defend these and any related claims vigorously.

Whistleblower lawsuits—The Company is also subject to *qui tam* or “whistleblower” lawsuits under the federal False Claims Act and comparable state laws for allegedly submitting fraudulent bills for services to the Medicare and Medicaid programs. These lawsuits can result in monetary damages, fines, attorneys’ fees, and the award of bounties to private *qui tam* plaintiffs who successfully bring these lawsuits and to the respective government programs. The Company also could be subject to civil penalties (including the loss of the Company’s licenses to operate one or more facilities or healthcare activities), criminal penalties (for violations of certain laws and regulations), and exclusion of one or more facilities or healthcare activities from participation in the Medicare, Medicaid, and other federal and state healthcare programs. The lawsuits are in various stages of adjudication or investigation and involve a wide variety of claims and potential outcomes.

Employment-related lawsuits—The Company’s operations are subject to a variety of federal and state employment-related laws and regulations, including but not limited to the U.S. Fair Labor Standards Act (“FLSA”), Equal Employment Opportunity laws, and enforcement policies of the Equal Employment Opportunity Commission, the Office of Civil Rights and state attorneys general, federal and state wage and hour laws, and a variety of laws enacted by the federal and state governments that govern these and other employment-related matters. Accordingly, the Company is currently subject to employee-related claims, class actions and other lawsuits and proceedings in connection with the Company’s operations, including but not limited to those related to alleged wrongful discharge, illegal discrimination, and violations of equal employment and federal and state wage and hour laws. Because labor represents such a large portion of the Company’s operating costs, noncompliance with these evolving federal and state laws and regulations could subject the Company to significant back pay awards, fines, and additional lawsuits and proceedings. These claims, lawsuits, and proceedings are in various stages of adjudication or investigation and involve a wide variety of claims and potential outcomes.

As a result of the decertification of a wage and hour class action lawsuit ([Rindfleisch v. Gentiva](#)), single-plaintiff lawsuits with identical claims have been filed against the Company. Including [Rindfleisch](#), which has four plaintiffs, there are 143 lawsuits pending in federal district court for the Northern District of Georgia. These lawsuits pertain to a compensation plan that paid Gentiva’s home health employees on both a per visit and an hourly basis, thereby allegedly voiding their FLSA exempt status and entitling them to overtime pay. The plaintiffs in these lawsuits are seeking attorneys’ fees and costs, back wages and liquidated damages under the FLSA. The Company recorded an estimated loss contingency reserve of \$5.5 million related to these matters. At this time, no estimate of the possible loss or range of loss in excess of the amount accrued can be made regarding these lawsuits. The Company disputes the allegations made in these lawsuits and will defend these and any related claims vigorously.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 23 – LEGAL AND REGULATORY PROCEEDINGS (Continued)

Minimum staffing lawsuits—Various states in which the Company operates have established minimum staffing requirements or may establish minimum staffing requirements in the future. While the Company seeks to comply with all applicable staffing requirements, the regulations in this area are complex and the Company may experience compliance issues from time to time. Failure to comply with such minimum staffing requirements may result in one or more facilities failing to meet the conditions of participation under relevant federal and state healthcare programs and the imposition of significant fines, damages, or other sanctions.

Shareholder actions—The Company is also subject to lawsuits and other shareholder actions brought from time to time. A shareholder derivative action (the “Complaint”) is currently pending against certain of the Company’s current and former officers and directors in circuit court for Jefferson County, Kentucky. The Complaint also names the Company as a nominal defendant. The Complaint alleges that the named current and former officers and directors breached their respective duties of good faith, loyalty, and candor, and other general fiduciary duties owed to the Company and its shareholders by, among other things, failing to exercise reasonable and prudent supervision over the management, policies, and controls of the Company in order to detect practices that existed at RehabCare resulting in the Company having to enter into two separate settlement agreements with the DOJ. The Company disputes the allegations made in the Complaint and will defend this action and any related claims vigorously.

Ordinary course matters—In addition to the matters described above, the Company is subject to investigations, claims, and lawsuits in the ordinary course of business, including investigations resulting from the Company’s obligation to self-report suspected violations of law and professional liability claims, particularly in the Company’s hospital and nursing center operations. In many of these claims, plaintiffs’ attorneys are seeking significant fines and compensatory and punitive damages in addition to attorneys’ fees. The Company maintains professional and general liability insurance in amounts and coverage that management believes are sufficient for the Company’s operations. However, the Company’s insurance may not cover all claims against the Company or the full extent of its liability.

KINDRED HEALTHCARE, INC.
QUARTERLY CONSOLIDATED FINANCIAL INFORMATION (UNAUDITED)
(In thousands, except per share amounts)

The following table represents summary quarterly consolidated financial information (unaudited) for the years ended December 31, 2016 and 2015:

	2016 (a)			
	<u>First</u>	<u>Second</u>	<u>Third</u>	<u>Fourth</u>
Revenues	\$ 1,837,971	\$ 1,842,070	\$ 1,793,527	\$ 1,745,951
Net income (loss):				
Income (loss) from continuing operations	25,837	34,381	(671,295)	(6,458)
Discontinued operations, net of income taxes:				
Income (loss) from operations	(582)	3,016	(12)	4,194
Gain (loss) on divestiture of operations	262	(83)	-	116
Income (loss) from discontinued operations	(320)	2,933	(12)	4,310
Net income (loss)	25,517	37,314	(671,307)	(2,148)
(Earnings) loss attributable to noncontrolling interests:				
Continuing operations	(12,514)	(13,522)	(14,305)	(13,261)
Discontinued operations	(2)	(3)	(1)	2
	(12,516)	(13,525)	(14,306)	(13,259)
Income (loss) attributable to Kindred	13,001	23,789	(685,613)	(15,407)
Earnings (loss) per common share:				
Basic:				
Income (loss) from continuing operations	0.15	0.24	(7.89)	(0.23)
Discontinued operations:				
Income (loss) from operations	-	0.03	-	0.05
Gain (loss) on divestiture of operations	-	-	-	-
Income (loss) from discontinued operations	-	0.03	-	0.05
Net income (loss)	0.15	0.27	(7.89)	(0.18)
Diluted:				
Income (loss) from continuing operations	0.15	0.23	(7.89)	(0.23)
Discontinued operations:				
Income (loss) from operations	-	0.03	-	0.05
Gain (loss) on divestiture of operations	-	-	-	-
Income (loss) from discontinued operations	-	0.03	-	0.05
Net income (loss)	0.15	0.26	(7.89)	(0.18)
Shares used in computing earnings (loss) per common share:				
Basic	86,590	86,836	86,869	86,904
Diluted	87,249	87,500	86,869	86,904
Market prices:				
High	12.65	15.66	12.55	10.69
Low	7.96	10.43	9.67	5.65

(a) See Note 4 for a discussion of impairment charges and Note 10 for a discussion on deferred tax valuation allowances.

KINDRED HEALTHCARE, INC.
QUARTERLY CONSOLIDATED FINANCIAL INFORMATION (UNAUDITED) (Continued)
(In thousands, except per share amounts)

	2015 (a)			
	First	Second	Third	Fourth
Revenues	\$ 1,675,967	\$ 1,833,475	\$ 1,764,516	\$ 1,780,949
Net income (loss):				
Income (loss) from continuing operations	(134,588)	33,710	(6,969)	55,984
Discontinued operations, net of income taxes:				
Income (loss) from operations	(3,424)	(589)	2,269	1,509
Gain on divestiture of operations	-	983	-	261
Income (loss) from discontinued operations	(3,424)	394	2,269	1,770
Net income (loss)	(138,012)	34,104	(4,700)	57,754
(Earnings) loss attributable to noncontrolling interests:				
Continuing operations	(8,847)	(11,735)	(9,900)	(12,082)
Discontinued operations	29	2	1	2
	(8,818)	(11,733)	(9,899)	(12,080)
Income (loss) attributable to Kindred	(146,830)	22,371	(14,599)	45,674
Earnings (loss) per common share:				
Basic:				
Income (loss) from continuing operations	(1.80)	0.25	(0.20)	0.50
Discontinued operations:				
Income (loss) from operations	(0.04)	(0.01)	0.03	0.02
Gain on divestiture of operations	-	0.01	-	-
Income (loss) from discontinued operations	(0.04)	-	0.03	0.02
Net income (loss)	(1.84)	0.25	(0.17)	0.52
Diluted:				
Income (loss) from continuing operations	(1.80)	0.25	(0.20)	0.50
Discontinued operations:				
Income (loss) from operations	(0.04)	(0.01)	0.03	0.02
Gain on divestiture of operations	-	0.01	-	-
Income (loss) from discontinued operations	(0.04)	-	0.03	0.02
Net income (loss)	(1.84)	0.25	(0.17)	0.52
Shares used in computing earnings (loss) per common share:				
Basic	79,575	86,045	86,184	86,336
Diluted	79,575	86,402	86,184	87,232
Market prices:				
High	24.65	24.66	23.36	15.75
Low	16.94	20.25	15.61	11.12

(a) See Note 4 for a discussion of impairment charges.

KINDRED HEALTHCARE, INC.
SCHEDULE II — VALUATION AND QUALIFYING ACCOUNTS
FOR THE YEARS ENDED DECEMBER 31, 2016, 2015 AND 2014
(In thousands)

	Balance at beginning of period	Additions			Deductions or payments	Balance at end of period
		Charged to cost and expenses	Other	Acquisitions		
Allowance for loss on accounts receivable:						
Year ended December 31, 2014	\$ 41,025	\$ 41,803	\$ -	\$ -	\$ (29,973)	\$ 52,855
Year ended December 31, 2015	52,855	52,460	-	-	(42,419)	62,896
Year ended December 31, 2016	62,896	40,804	-	-	(32,630)	71,070
Allowance for deferred taxes (a):						
Year ended December 31, 2014	\$ 49,743	\$ -	\$ 1,226	\$ -	\$ -	\$ 50,969
Year ended December 31, 2015	50,969	-	-	10,063	(14,356)	46,676
Year ended December 31, 2016	46,676	385,752	-	(86)	(9,188)	423,154

- (a) The Company identified deferred income tax assets for federal income tax NOLs of \$162.4 million, \$119.1 million and \$51.4 million at December 31, 2016, December 31, 2015 and December 31, 2014, respectively, with a corresponding federal deferred income tax valuation allowance of \$162.4 million at December 31, 2016 after determining that these federal net deferred income tax assets were not realizable. There were no corresponding federal deferred income tax valuation allowances at December 31, 2015 and December 31, 2014. The Company identified deferred income tax assets for state income tax NOLs of \$60.4 million, \$60.0 million and \$68.8 million at December 31, 2016, December 31, 2015 and December 31, 2014, respectively, and a corresponding state deferred income tax valuation allowance of \$60.0 million, \$46.7 million and \$50.9 million at December 31, 2016, December 31, 2015 and December 31, 2014, respectively, after determining that all or a portion of these state net deferred income tax assets were not realizable.

**AMENDED AND RESTATED
EMPLOYMENT AGREEMENT**

This AMENDED AND RESTATED EMPLOYMENT AGREEMENT (the "Agreement") is made on November 15, 2016 (the "Effective Date"), by and between Kindred Healthcare Operating, Inc., a Delaware corporation (the "Company"), and Michael W. Beal (the "Executive").

WITNESSETH:

WHEREAS, the Executive is employed by the Company, a wholly-owned subsidiary of Kindred Healthcare, Inc. ("Parent"), and the parties hereto desire to revise the terms of Executive's employment by the Company on and after the Effective Date; and

WHEREAS, the Executive Compensation Committee of the Board of Directors of the Parent has determined that it is in the best interests of the Company and Parent to enter into this Agreement.

NOW, THEREFORE, in consideration of the premises and the respective covenants and agreements contained herein, and intending to be legally bound hereby, the Company and Executive agree as follows:

1. **Employment.** The Company hereby agrees to employ Executive and Executive hereby agrees to be employed by the Company on the terms and conditions herein set forth. This Agreement shall become effective on the Effective Date and, unless otherwise earlier terminated as set forth herein, shall expire on the later of (a) December 31, 2017, or (b) five days following receipt of the Exit Notice (as defined below) (the "Term"). Company and Executive acknowledge and agree that the Company intends to divest of all of its nursing center operations (the "Nursing Center Exit") and that Executive is being retained to assist in the Nursing Center Exit. When the Company has determined in its sole discretion that it has completed the Nursing Center Exit, it shall provide Executive with a written notice of such event (the "Exit Notice").

2. **Duties.** Executive is engaged by the Company as President, Nursing Center Division.

3. **Extent of Services.** Executive, subject to the direction and control of the Board of Directors (the "Board"), shall have the power and authority commensurate with his executive status and necessary to perform his duties hereunder. During the Term, Executive shall devote his entire working time, attention, labor, skill and energies to the business of the Company, and shall not, without the consent of the Company, be actively engaged in any other business activity, whether or not such business activity is pursued for gain, profit or other pecuniary advantage.

4. Compensation. As compensation for services hereunder rendered, Executive shall receive during the Term:

(a) A base salary ("Base Salary") of \$404,000 per year payable in equal installments in accordance with the Company's normal payroll procedures.

(b) In addition to Base Salary, Executive shall be entitled to receive bonuses and other incentive compensation as the Board may approve from time to time, including participation in the Company's annual short-term incentive compensation plan and long-term incentive compensation plan, in accordance with the terms and conditions of such plans as may be in effect from time to time, subject to the following:

(i) For 2017, in lieu of a bonus under the short-term incentive plan, Executive will receive a one-time lump sum cash payment of \$202,000 (the "2017 Bonus"). Any such 2017 Bonus will be paid within 14 days following December 31, 2017.

(ii) For 2017, the Executive's target bonus under the long-term incentive plan shall be 50% of Base Salary and shall be subject to the other terms and conditions of the long-term incentive plan.

(iii) If Executive's employment continues into 2018, Executive shall continue to participate in the Company's short-term and long-term incentive plans, with any resulting award paid on a prorated basis (based on the number of days during 2018 Executive is employed by the Company), assuming target performance is achieved, and subject to the other terms and conditions of such plans.

5. Benefits.

(a) Executive shall be entitled to participate during the Term in any and all pension benefit, welfare benefit (including, without limitation, medical, dental, disability and group life insurance coverages) and fringe benefit plans from time to time in effect for officers of the Company and its affiliates.

(b) During the Term, Executive shall be entitled to participate in such equity plans of the Company and its affiliates in effect from time to time for officers of the Company.

(c) Executive shall be entitled to paid time off each year, subject to the Company's policies, as in effect from time to time for the Company's executive officers. The Executive shall schedule the timing of such vacations in a reasonable manner. The Executive may also be entitled to such other leave, with or without compensation, as shall be mutually agreed by the Company and Executive.

(d) Executive may incur reasonable expenses for promoting the Company's business, including expenses for entertainment, travel and similar items. The Company shall reimburse Executive for all such reasonable expenses in accordance with the Company's reimbursement policies and procedures, as may be in effect from time to

time. The Company agrees to reimburse Executive his legal fees incurred in reviewing and negotiating this Agreement, not to exceed \$7,500.

(e) Within 14 days of delivery of the Exit Notice, Executive shall receive a lump sum cash payment of \$500,000 from the Company, provided that Executive remains employed by the Company on such date.

6. Termination of Employment.

(a) Death or Disability. Executive's employment shall terminate automatically upon Executive's death during the Term. If the Company determines in good faith that the Disability of Executive has occurred during the Term (pursuant to the definition of Disability set forth below) it may give to Executive written notice of its intention to terminate Executive's employment. In such event, Executive's employment with the Company shall terminate effective on the 30th day after receipt of such notice by Executive (the "Disability Effective Date"), provided that, within the 30 days after such receipt, Executive shall not have returned to full-time performance of Executive's duties. For purposes of this Agreement, "Disability" shall mean Executive's absence from his full-time duties hereunder for a period of 90 days due to disability as defined in the long-term disability plan provided to Executive by the Company.

(b) Cause. The Company may terminate Executive's employment during the Term for Cause. For purposes of this Agreement, "Cause" shall mean the Executive's (i) conviction of or plea of nolo contendere to a crime involving moral turpitude; or (ii) willful and material breach by Executive of his duties and responsibilities, which is committed in bad faith or without reasonable belief that such breaching conduct is in the best interests of the Company and its affiliates, but with respect to (ii) only if the Board adopts a resolution by a vote of at least 75% of its members so finding after giving the Executive and his attorney an opportunity to be heard by the Board and a reasonable opportunity of not less than 30 days to remedy or correct the purported breaching conduct. Any act, or failure to act, based upon authority given pursuant to a resolution duly adopted by the Board or based upon advice of counsel for the Company shall be conclusively presumed to be done, or omitted to be done, by Executive in good faith and in the best interests of the Company.

(c) Good Reason. Executive's employment may be terminated during the Term by Executive for Good Reason. "Good Reason" shall exist upon the occurrence, without Executive's express written consent, of any of the following events during the Term:

(i) a material adverse change in Executive's authority, duties or responsibilities (including, without limitation the Company assigning to Executive duties of a substantially nonexecutive or nonmanagerial nature) (other than any such change directly attributable to (a) changes in his authority, duties or responsibilities resulting from the Nursing Center Exit; or (b) the fact that the Company is no longer publicly owned);

(ii) the Company shall materially reduce the Base Salary or annual bonus opportunity of Executive except as provided in this Agreement;

(iii) the Company shall require Executive to relocate Executive's principal business office more than 30 miles from its location on the Effective Date, which shall be 680 South Fourth Street, Louisville, KY; or

(iv) a material breach by the Company of Section 5(a) or Section 9(c) of this Agreement.

For purposes of this Agreement, "Good Reason" shall not exist until after Executive has given the Company notice of the applicable event within 90 days of the initial occurrence of such event and which is not remedied within 30 days after receipt of written notice from Executive specifically delineating such claimed event and setting forth Executive's intention to terminate employment if not remedied; provided, that if the specified event cannot reasonably be remedied within such 30-day period and the Company commences reasonable steps within such 30-day period to remedy such event and diligently continues such steps thereafter until a remedy is effected, such event shall not constitute "Good Reason" provided that such event is remedied within 60 days after receipt of such written notice.

(d) Notice of Termination. Any termination by the Company for Cause, or by Executive for Good Reason, shall be communicated by Notice of Termination given in accordance with this Agreement. For purposes of this Agreement, a "Notice of Termination" means a written notice which (i) indicates the specific termination provision in this Agreement relied upon, (ii) sets forth in reasonable detail the facts and circumstances claimed to provide a basis for termination of Executive's employment under the provision so indicated and (iii) specifies the intended termination date (which date, in the case of a termination for Good Reason, shall be not more than thirty days after the giving of such notice). The failure by Executive or the Company to set forth in the Notice of Termination any fact or circumstance which contributes to a showing of Good Reason or Cause shall not waive any right of Executive or the Company, respectively, hereunder or preclude Executive or the Company, respectively, from asserting such fact or circumstance in enforcing Executive's or the Company's rights hereunder.

(e) Date of Termination. "Date of Termination" means (i) if during the Term, Executive's employment is terminated by the Company for Cause, or by Executive for Good Reason, the later of the date specified in the Notice of Termination or the date that is one day after the last day of any applicable cure period, (ii) if during the Term, Executive's employment is terminated by the Company other than for Cause or Disability, or Executive resigns without Good Reason, the Date of Termination shall be the date on which the Company or Executive notified Executive or the Company, respectively, of such termination, (iii) if during the Term, Executive's employment is terminated by reason of death or Disability, the Date of Termination shall be the date of death of Executive or the Disability Effective Date, as the case may be, or (iv) upon expiration of the Term.

7. Obligations of the Company Upon Termination. Following any termination of Executive's employment hereunder, the Company shall pay Executive his Base Salary through the Date of Termination and any amounts owed to Executive pursuant to the terms and conditions of the benefit plans and programs of the Company at the time such payments are due. In addition, subject to Section 7(e) hereof and the conditions set forth below, Executive shall be entitled to the following additional payments:

(a) Death or Disability. If, during the Term, Executive's employment shall terminate by reason of Executive's death or Disability, the Company shall pay to Executive (or his designated beneficiary or estate, as the case may be) the prorated portion of the 2017 Bonus Executive would have received for the 2017 calendar year (or the 2018 calendar year if the Termination Date does not occur prior to January 1, 2018). Such amount shall be paid on the date when such amounts would otherwise have been payable to the Executive if Executive's employment with the Company had not terminated as determined in accordance with the terms and conditions of this Agreement.

(b) Expiration of the Term; Good Reason; Other than for Cause. If (i) during the Term, (a) the Company shall terminate Executive's employment other than for Cause (but not for Disability), or (b) the Executive shall terminate his employment for Good Reason, or (ii) Executive's employment shall terminate upon expiration of the Term:

(1) Within 14 days following Executive's Date of Termination, the Company shall pay to Executive a cash severance payment of \$909,000.

(2) For a period of 18 months following the Date of Termination (the "Benefit Continuation Period"), the Executive shall be entitled to participate in any and all welfare benefit (including, without limitation, medical, dental, disability, and group life insurance coverage) and fringe benefit plans from time to time in effect for officers of the Company and its subsidiaries. Executive shall be responsible for any cost for such insurance coverage; provided, however, that the Company will pay to Executive a lump sum payment equal to the monthly employer subsidy of such costs for the duration of the Benefit Continuation Period, plus an amount necessary to cover any taxes incurred by Executive related to such payment. Following the Benefit Continuation Period, the Executive shall be entitled to receive continuation coverage under Part 6 of Title I or ERISA by treating the end of this period as the applicable qualifying event (i.e., as a termination of employment) for purposes of ERISA Section 603(2)) and with the concurrent loss of coverage occurring on the same date, to the extent allowed by applicable law.

(3) For the Benefit Continuation Period, Company shall maintain in force, at its expense, the Executive's life insurance in effect under the Company's voluntary life insurance benefit plan as of the Date of Termination. Executive shall be responsible for any employee contributions for such insurance coverage. For purposes of clarification, the portion of the premiums in respect of such voluntary life insurance for which Executive and Company are responsible,

respectively, shall be the same as the portion for which Company and Executive are responsible, respectively, immediately prior to the Date of Termination.

(4) For the Benefit Continuation Period, the Company shall provide short-term and long-term disability insurance benefits to Executive equivalent to the coverage that the Executive would have had if he had remained employed under the disability insurance plans applicable to Executive on the Date of Termination. Executive shall be responsible for any employee contributions for such insurance coverage. Should Executive become disabled during such period, Executive shall be entitled to receive such benefits, and for such duration, as the applicable plan provides. For purposes of clarification, the portion of the premiums in respect of such short-term and long-term disability benefits for which Executive and Company are responsible, respectively, shall be the same as the portion for which Executive and Company are responsible, respectively, immediately prior to the Date of Termination.

(5) Within fifteen (15) days after the Date of Termination, the Company shall pay to Executive a cash payment in an amount, if any, necessary to compensate Executive for the Executive's unvested interests under the Company's retirement savings plan which are forfeited by Executive in connection with the termination of Executive's employment.

(6) If Executive's Date of Termination occurs prior to December 31, 2017, then within 14 days of the Date of Termination, the Company shall pay to Executive a lump sum cash payment equal to the amounts set forth in Sections 4(a) and 4(b)(i) herein that are unpaid as of such Date of Termination that Executive would otherwise be entitled to receive had he remained employed through December 31, 2017.

(7) Company may adopt such amendments to its executive benefit plans, if any, as are necessary to effectuate the provisions of this Agreement.

(8) Any outstanding unvested stock options, stock performance units or similar equity awards (other than restricted stock awards) held by Executive on the Date of Termination shall continue to vest in accordance with their original terms (including any related performance measures) for the duration of the Benefit Continuation Period as if Executive had remained an employee of the Company through the end of such period and any such stock option, stock performance unit or other equity award (other than restricted stock awards) that has not vested as of the conclusion of such period shall be immediately cancelled and forfeited as of such date. In addition, Executive shall have the right to continue to exercise any outstanding vested stock options held by Executive during the Benefit Continuation Period; provided that in no event shall Executive be entitled to exercise any such option beyond the original expiration date of such option. Any outstanding restricted stock award held by Executive as of the Date of Termination that would have vested during the Benefit Continuation Period had Executive remained an employee of the Company through the end of such

period shall be immediately vested as of the Date of Termination and any restricted stock award that would not have vested as of the conclusion of such period shall be immediately cancelled and forfeited as of such date.

(9) Following the Executive's Date of Termination, the Executive shall receive the computer which Executive is utilizing as of the Date of Termination.

(10) Notwithstanding anything in this Agreement to the contrary, in no event shall the provision of in-kind benefits pursuant to this Section 7 during any taxable year of Executive affect the provision of in-kind benefits pursuant to this Section 7 in any other taxable year of Executive.

(c) Cause; Other than for Good Reason. If Executive's employment shall be terminated for Cause or Executive terminates employment without Good Reason (and other than due to such Executive's death) during the Term, this Agreement shall terminate without further additional obligations to Executive under this Agreement.

(d) Death after Termination. In the event of the death of Executive during the period Executive is receiving payments pursuant to this Agreement, Executive's designated beneficiary shall be entitled to receive the balance of the payments; or in the event of no designated beneficiary, the remaining payments shall be made to Executive's estate.

(e) General Release of Claims. Notwithstanding anything herein to the contrary, the amounts payable pursuant to this Section 7 are subject to the condition that Executive has delivered to the Company an executed copy of an irrevocable general release of claims in a form satisfactory to the Company within the 60 day period immediately following the Executive's separation from service (the "Release Period"). Any payment that otherwise would be made prior to Executive's delivery of such executed release pursuant to this Section 7 shall be paid on the first business day following the conclusion of the Release Period; provided that in-kind benefits provided pursuant to subsections (b)(2), (3) and (4) of this Section 7 shall continue in effect after separation from service pending the execution and delivery of such release for a period not to exceed 60 days; provided further that if such release is not executed and delivered within such 60-day period, Executive shall reimburse the Company for the full cost of coverage during such period.

(f) Six Month Delay for Specified Employees. Notwithstanding anything herein to the contrary, if at the time of Executive's separation from service Executive is a "specified employee" as defined in Section 409A of the Internal Revenue Code of 1986, as amended and the regulations promulgated thereunder (the "Code") and the deferral of the payments payable pursuant to Sections 5(e) and 7(b) are necessary in order to prevent any accelerated or additional tax under Section 409A of the Code, then the payments to which Executive would otherwise be entitled during the first six months following his separation from service shall be deferred and accumulated (without any reduction in such payment ultimately paid to Executive) for a period of six months from the date of separation from service and paid in a lump sum on the first day of the seventh month

following such separation from service (or, if earlier, the date of Executive's death), together with interest during such period at a rate computed by adding 2.00% to the Prime Rate as published in the Money Rates section of the Wall Street Journal, or other equivalent publication if the Wall Street Journal no longer publishes such information, on the first publication date of the Wall Street Journal or equivalent publication after the date of Executive's separation from service (provided that if more than one such Prime Rate is published on any given day, the highest of such published rates shall be used).

8. Payments Due as of December 31, 2017. In recognition of Executive continuing his employment through December 31, 2017, the Company agrees that if Executive is still employed by Company on December 31, 2017, then Executive shall be entitled to receive the payment described in Section 4(b)(i). Company shall pay Executive such amount by January 15, 2018.

9. Disputes. Any dispute or controversy arising under, out of, or in connection with this Agreement shall, at the election and upon written demand of either party, be finally determined and settled by binding arbitration in the City of Louisville, Kentucky, in accordance with the Labor Arbitration rules and procedures of the American Arbitration Association, and judgment upon the award may be entered in any court having jurisdiction thereof. The Company shall pay all costs of the arbitration and all reasonable attorneys' and accountants' fees of the Executive in connection therewith, including any litigation to enforce any arbitration award.

10. Successors.

(a) This Agreement is personal to Executive and without the prior written consent of the Company shall not be assignable by Executive otherwise than by will or the laws of descent and distribution. This Agreement shall inure to the benefit of and be enforceable by Executive's legal representatives.

(b) This Agreement shall inure to the benefit of and be binding upon the Company and its successors and assigns.

(c) The Company shall require any successor (whether direct or indirect, by purchase, merger, consolidation or otherwise) to all or substantially all of the business and/or assets of the Company, or any business of the Company for which Executive's services are principally performed, to assume expressly and agree to perform this Agreement in the same manner and to the same extent that the Company would be required to perform it if no such succession had taken place. As used this Agreement, "Company" shall mean the Company as hereinbefore defined and any successor to its business and/or assets as aforesaid which assumes and agrees to perform this Agreement by operation of law, or otherwise.

11. Other Severance Benefits. Executive hereby agrees that in consideration for the payments to be received under Sections 4(b), 4(c), and 7(b) of this Agreement, Executive waives any and all rights to any payments or benefits under any severance plans or arrangements of the Company or their respective affiliates that specifically provide for severance payments, other than the Change in Control Severance Agreement between the Company and Executive

(the “Change in Control Severance Agreement”); provided that any payments payable to Executive under Sections 7(b) hereof shall offset any payments payable under the Change in Control Severance Agreement.

12. Withholding. All payments to be made to Executive hereunder will be subject to all applicable required withholding of taxes.

13. Non-solicitation. During the Term and for a period of one year thereafter (collectively, the “Non-solicitation Period”), Executive shall not directly or indirectly, individually or on behalf of any person other than the Company, aid or endeavor to solicit or induce any of the Company’s or its affiliates’ employees to leave their employment with the Company or such affiliates in order to accept employment with Executive or any other person, corporation, limited liability company, partnership, sole proprietorship or other entity; provided, however, that the foregoing shall not restrict Executive or any other person from conducting general solicitations or advertisements not directed specifically at employees of the Company or its affiliates, or from employing any employee who responds to any such general solicitation or advertisement or who otherwise initiates a request for employment. If the restrictions set forth in this section would otherwise be determined to be invalid or unenforceable by a court of competent jurisdiction, the parties intend and agree that such court shall exercise its discretion in reforming the provisions of this Agreement to the end that Executive will be subject to a non-solicitation covenant which is reasonable under the circumstances and enforceable by the Company. It is agreed that no adequate remedy at law exists for the parties for violation of this section and that this section may be enforced by any equitable remedy, including specific performance and injunction, without limiting the right of the Company to proceed at law to obtain such relief as may be available to it. The running of the Non-solicitation Period shall be tolled for any period of time during which Executive is in violation of any covenant contained herein, for any reason whatsoever.

14. No Mitigation. Executive shall have no duty to mitigate his damages by seeking other employment and, should Executive actually receive compensation from any such other employment, the payments required hereunder (including, without limitation, the provision of in-kind benefits provided under Section 7(b) hereof) shall not be reduced or offset by any such compensation. Further, the Company’s and Parent’s obligations to make any payments hereunder shall not be subject to or affected by any setoff, counterclaims or defenses which the Company or Parent may have against Executive or others.

15. Notices. Any notice required or permitted to be given under this Agreement shall be in writing and shall be deemed to have been duly given when delivered or sent by telephone facsimile transmission, personal or overnight couriers, or registered mail with confirmation or receipt, addressed as follows:

If to Executive:
Michael W. Beal
680 South Fourth Street
Louisville, KY 40202

with a copy to:

Dennis D. Murrell
Middleton Reutlinger
2500 Brown & Williamson Tower
401 S. Fourth St.
Louisville, KY 40202

If to Company:
Kindred Healthcare Operating, Inc.
680 South Fourth Street
Louisville, KY 40202
Attn: General Counsel

16. Waiver of Breach and Severability. The waiver by either party of a breach of any provision of this Agreement by the other party shall not operate or be construed as a waiver of any subsequent breach by either party. In the event any provision of this Agreement is found to be invalid or unenforceable, it may be severed from the Agreement and the remaining provisions of the Agreement shall continue to be binding and effective.

17. Entire Agreement; Amendment. This instrument contains the entire agreement of the parties with respect to the subject matter hereof and supersedes all prior agreements, promises, covenants, arrangements, communications, representations and warranties between them, whether written or oral with respect to the subject matter hereof. No provisions of this Agreement may be modified, waived or discharged unless such modification, waiver or discharge is agreed to in writing signed by Executive and such officer of the Company specifically designated by the Board.

18. Governing Law. This Agreement shall be construed in accordance with and governed by the laws of the State of Delaware.

19. Headings. The headings in this Agreement are for convenience only and shall not be used to interpret or construe its provisions.

20. Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument.

21. Cancellation of Prior Agreement. The Executive hereby acknowledges and agrees that this Agreement is intended to and does hereby replace that certain employment agreement dated April 16, 2014, and any amendments thereto, between the Company and the Executive, and that such agreement is cancelled, terminated and of no further force and effect. For purposes of clarity, this Agreement has no effect on the Change in Control Agreement dated April 16, 2014 which remains binding between the parties.

22. Section 409A. If any provision of this Agreement (or any award of compensation or benefits provided under this Agreement) would cause Executive to incur any additional tax or interest under Section 409A of the Code, the Company shall reform such provision to comply with 409A and agrees to maintain, to the maximum extent practicable without violating 409A of the Code, the original intent and economic benefit to Executive of the applicable provision; provided that nothing herein shall require the Company to provide Executive with any gross-up for any tax, interest or penalty incurred by Executive under Section 409A of the Code.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first above written.

KINDRED HEALTHCARE OPERATING, INC.

By: /s/ Benjamin A. Breier
Benjamin A. Breier
President and Chief Executive Officer

Solely for the purpose of Section 7

KINDRED HEALTHCARE, INC.

By: /s/ Benjamin A. Breier
Benjamin A. Breier
President and Chief Executive Officer

/s/ Michael W. Beal
MICHAEL W. BEAL

REGISTRANT'S SUBSIDIARIES

January 3, 2017

Comerstone Insurance Company, a Cayman Islands corporation

Kindred Healthcare Operating, Inc., a Delaware corporation

Kindred Development 27, L.L.C., a Delaware limited liability company

Kindred Healthcare Development 2, Inc., a Delaware corporation

Kindred Hospitals East, L.L.C., a Delaware limited liability company

Goddard Nursing, L.L.C., a Delaware limited liability company

Kindred Braintree Hospital, L.L.C., a Delaware limited liability company

Kindred Hospital Palm Beach, L.L.C., a Delaware limited liability company

Kindred Hospital-Pittsburgh-North Shore, L.L.C., a Delaware limited liability company

Kindred Development 17, L.L.C., a Delaware limited liability company

Springfield Park View Hospital, L.L.C., a Delaware limited liability company

Kindred Hospitals West, L.L.C., a Delaware limited liability company

Kindred Nursing Centers East, L.L.C., a Delaware limited liability company

Avery Manor Nursing, L.L.C., a Delaware limited liability company

Braintree Nursing, L.L.C., a Delaware limited liability company

Country Estates Nursing, L.L.C., a Delaware limited liability company

Forestview Nursing, L.L.C., a Delaware limited liability company

Greens Nursing and Assisted Living, L.L.C., a Delaware limited liability company

Harborlights Nursing, L.L.C., a Delaware limited liability company

Highgate Nursing, L.L.C., a Delaware limited liability company

Highlander Nursing, L.L.C., a Delaware limited liability company

Kindred Development Holdings 3, L.L.C., a Delaware limited liability company

Kindred Development Holdings 5, L.L.C., a Delaware limited liability company

Kindred Development 7, L.L.C., a Delaware limited liability company

Kindred Development 8, L.L.C., a Delaware limited liability company

Physician Housecalls, LLC, a Colorado limited liability company
Kindred Development 9, L.L.C., a Delaware limited liability company
House Call Doctors, Inc., a Texas corporation
Kindred Development 10, L.L.C., a Delaware limited liability company
Kindred Development 11, L.L.C., a Delaware limited liability company
Kindred Development 12, L.L.C., a Delaware limited liability company
Kindred Development 13, L.L.C., a Delaware limited liability company
Laurel Lake Health and Rehabilitation, L.L.C., a Delaware limited liability company
Massachusetts Assisted Living, L.L.C., a Delaware limited liability company
Meadows Nursing, L.L.C., a Delaware limited liability company
Tower Hill Nursing, L.L.C., a Delaware limited liability company
Kindred Nursing Centers West, L.L.C., a Delaware limited liability company
Maine Assisted Living, L.L.C., a Delaware limited liability company
California Nursing Centers, L.L.C., a Delaware limited liability company
Bayberry Care Center, L.L.C., a Delaware limited liability company
Care Center of Rossmoor, L.L.C., a Delaware limited liability company
Greenbrae Care Center, L.L.C., a Delaware limited liability company
Medical Hill Rehab Center, L.L.C., a Delaware limited liability company
Pacific Coast Care Center, L.L.C., a Delaware limited liability company
Siena Care Center, L.L.C., a Delaware limited liability company
Smith Ranch Care Center, L.L.C., a Delaware limited liability company
Ygnacio Valley Care Center, L.L.C., a Delaware limited liability company
Kindred Nevada, L.L.C., a Delaware limited liability company
Kindred Systems, Inc., a Delaware corporation
Kindred Healthcare Services, Inc., a Delaware corporation
Ledgewood Health Care Corporation, a Massachusetts corporation

Kindred Rehab Services, Inc., a Delaware corporation

 TherEx, Inc., a Delaware corporation

 The Therapy Group, Inc., a Louisiana corporation

Peoplefirst Virginia, L.L.C., a Delaware limited liability company

Kindred Hospice Services, L.L.C., a Delaware limited liability company

 Peoplefirst HomeCare & Hospice of Colorado, L.L.C., a Delaware limited liability company

 Peoplefirst HomeCare of Colorado, L.L.C., a Delaware limited liability company

 Peoplefirst HomeCare & Hospice of Indiana, L.L.C., a Delaware limited liability company

 Peoplefirst HomeCare & Hospice of Massachusetts, L.L.C., a Delaware limited liability company

 Peoplefirst HomeCare & Hospice of Ohio, L.L.C., a Delaware limited liability company

 PF Development 15, L.L.C., a Delaware limited liability company

PF Development 5, L.L.C., a Delaware limited liability company

PF Development 6, L.L.C., a Delaware limited liability company

PF Development 7, L.L.C., a Delaware limited liability company

PF Development 8, L.L.C., a Delaware limited liability company

PF Development 9, L.L.C., a Delaware limited liability company

 IntegraCare Holdings, Inc., a Delaware corporation

 Aberdeen Holdings, Inc., a Texas corporation

 IntegraCare Home Health Services, Inc., a Texas corporation

 IntegraCare of Texas, LLC, a Texas limited liability company

 GBA Holdings, Inc., a Texas corporation

 Focus Care Health Resources, Inc., a Texas corporation

 IntegraCare Intermediate Holdings, Inc., a Delaware corporation

 Able Home Healthcare, Inc., a Texas corporation

 Compass Hospice, Inc., a Texas corporation

 GBA West, LLC, a Texas limited liability company

 IntegraCare of Olney Home Health, LLC, a Texas limited liability company

 IntegraCare of Athens-Home Health, LLC, a Texas limited liability company

IntegraCare of Athens-Hospice, LLC, a Texas limited liability company
IntegraCare of Albany, LLC, a Texas limited liability company
IntegraCare of Granbury, LLC, a Texas limited liability company
Home Health of Rural Texas, Inc., a Texas corporation
Trinity Hospice of Texas, LLC, a Texas limited liability company
IntegraCare of Abilene, LLC, a Texas limited liability company
IntegraCare Hospice of Abilene, LLC, a Texas limited liability company
IntegraCare of Littlefield, LLC, a Texas limited liability company
IntegraCare of Wichita Falls, LLC, a Texas limited liability company
IntegraCare of West Texas Home Health, LLC, a Texas limited liability company
IntegraCare of West Texas-Hospice, LLC, a Texas limited liability company
Texas Health Management Group, LLC, a Texas limited liability company
Vernon Home Health Care Agency, LLC, a Texas limited liability company
Wellstream Health Services, LLC, a Texas limited liability company
West Texas, LLC, a Texas limited liability company
Outreach Health Services of the Panhandle, LLC, a Texas limited liability company
BWB Sunbelt Home Health Services, LLC, a Texas limited liability company
Outreach Health Services of North Texas, LLC, a Texas limited liability company
North West Texas Home Health Services, LLC, a Texas limited liability company

PF Development 10, L.L.C., a Delaware limited liability company

Professional Healthcare, LLC, a Delaware limited liability company

NP Plus, LLC, a Delaware limited liability company

Haven Health, LLC, a Delaware limited liability company

PHH Acquisition Corp., a Delaware corporation

Professional Healthcare at Home, LLC, a California limited liability company

HHS Healthcare Corp., a Delaware corporation

Home Health Services, Inc., a Utah corporation

Southern Utah Home Health, Inc., a Utah corporation

Southern Nevada Home Health Care, Inc., a Nevada corporation

Central Arizona Home Health Care, Inc., an Arizona corporation

KAH Development 16, Inc., a Utah corporation

PF Development 16, L.L.C., a Delaware limited liability company

PF Development 17, L.L.C., a Delaware limited liability company

PF Development 18, L.L.C., a Delaware limited liability company

PF Development 19, L.L.C., a Delaware limited liability company

DH/KND, L.L.C., a Delaware limited liability company

Community Home Health, L.L.C., a Delaware limited liability company

PF Development 20, L.L.C., a Delaware limited liability company

PF Development 21, L.L.C., a Delaware limited liability company

SHC Holding, Inc., a Delaware corporation

SHC Rehab, Inc., a Florida corporation

Senior Home Care, Inc., a Florida corporation

HomeCare Holdings, Inc., a Florida corporation

Med-Tech Services of Dade, Inc., a Florida corporation

Med-Tech Private Care, Inc., a Florida corporation

Advanced Oncology Services, Inc., a Florida corporation

Med. Tech. Services of South Florida, Inc., a Florida corporation

Med- Tech Services of Palm Beach, Inc., a Florida corporation

Synergy, Inc., a Louisiana corporation

Synergy Home Care – Capitol Region, Inc., a Louisiana corporation

Synergy Home Care – Northeastern Region, Inc., a Louisiana corporation

Synergy Home Care – Acadiana Region, Inc., a Louisiana corporation

Synergy Home Care – Southeastern Region, Inc., a Louisiana corporation

Synergy Home Care – Central Region, Inc., a Louisiana corporation

Synergy Home Care – Northwestern Region, Inc., a Louisiana corporation

Synergy Home Care – Northshore Region, Inc., a Louisiana corporation

Synergy Healthcare Group, Inc., a Louisiana corporation

PF Development 22, L.L.C., a Delaware limited liability company

Mills Medical Practices, LLC, an Ohio limited liability company

PF Development 23, L.L.C., a Delaware limited liability company

KAH Development 1, L.L.C., a Delaware limited liability company

KAH Development 2, L.L.C., a Delaware limited liability company

KAH Development 3, L.L.C., a Delaware limited liability company

Silver State ACO, LLC, a Nevada limited liability company

KAH Development 4, L.L.C., a Delaware limited liability company

KAH Development 5, L.L.C., a Delaware limited liability company

KAH Development 6, L.L.C., a Delaware limited liability company

KAH Development 7, L.L.C., a Delaware limited liability company

KAH Development 8, L.L.C., a Delaware limited liability company

KAH Development 9, L.L.C., a Delaware limited liability company

KAH Development 10, L.L.C., a Delaware limited liability company

KAH Development 11, L.L.C., a Delaware limited liability company

KAH Development 12, L.L.C., a Delaware limited liability company

KAH Development 13, L.L.C., a Delaware limited liability company

KAH Development 14, L.L.C., a Delaware limited liability company

KAH Development 15, L.L.C., a Delaware limited liability company

RehabCare Development 2, L.L.C., a Delaware limited liability company

East Valley Rehabilitation Hospital, L.L.C., a Delaware limited liability company

RehabCare Development 3, L.L.C., a Delaware limited liability company

RehabCare Development 4, L.L.C., a Delaware limited liability company

RehabCare Development 5, L.L.C., a Delaware limited liability company

KND Development 50, L.L.C., a Delaware limited liability company

KND Development 51, L.L.C., a Delaware limited liability company

KND Development 52, L.L.C., a Delaware limited liability company

KND Development 53, L.L.C., a Delaware limited liability company

KND Development 54, L.L.C., a Delaware limited liability company

KND Development 55, L.L.C., a Delaware limited liability company

KND Development 56, L.L.C., a Delaware limited liability company

Palomar / Kindred, LLC, a Delaware limited liability company

Palomar Long Term Acute Care Pavilion, LLC, a Delaware limited liability company

Palomar Health Rehabilitation Institute, LLC, a Delaware limited liability company

KND Development 57, L.L.C., a Delaware limited liability company

KND Development 59, L.L.C., a Delaware limited liability company

KND Development 62, L.L.C., a Delaware limited liability company

KND Development 63, L.L.C., a Delaware limited liability company

KND Real Estate Holdings, L.L.C., a Delaware limited liability company

KND Hospital Real Estate Holdings, L.L.C., a Delaware limited liability company

KND Real Estate 8, L.L.C., a Delaware limited liability company

KND Real Estate 9, L.L.C., a Delaware limited liability company

KND Real Estate 14, L.L.C., a Delaware limited liability company

KND Real Estate 20, L.L.C., a Delaware limited liability company

KND Real Estate 21, L.L.C., a Delaware limited liability company

KND Real Estate 22, L.L.C., a Delaware limited liability company

KND Real Estate 23, L.L.C., a Delaware limited liability company

KND Development 64, LLC, a Delaware limited liability company

KND Development 65, LLC, a Delaware limited liability company

KND Real Estate 26, L.L.C., a Delaware limited liability company

KND Development 66, LLC, a Delaware limited liability company

KND Development 67, LLC, a Delaware limited liability company

KND Real Estate 29, L.L.C., a Delaware limited liability company

KND Real Estate 30, L.L.C., a Delaware limited liability company

KND Development 68, LLC, a Delaware limited liability company

KND Real Estate 32, L.L.C., a Delaware limited liability company
KND Real Estate 46, L.L.C., a Delaware limited liability company
KND Development 69, LLC, a Delaware limited liability company
KND SNF Real Estate Holdings, L.L.C., a Delaware limited liability company
KND Real Estate 1, L.L.C., a Delaware limited liability company
KND Real Estate 2, L.L.C., a Delaware limited liability company
KND Real Estate 3, L.L.C., a Delaware limited liability company
KND Real Estate 4, L.L.C., a Delaware limited liability company
KND Real Estate 5, L.L.C., a Delaware limited liability company
KND Real Estate 6, L.L.C., a Delaware limited liability company
KND Real Estate 7, L.L.C., a Delaware limited liability company
KND Real Estate 10, L.L.C., a Delaware limited liability company
KND Real Estate 11, L.L.C., a Delaware limited liability company
KND Real Estate 12, L.L.C., a Delaware limited liability company
KND Real Estate 13, L.L.C., a Delaware limited liability company
KND Real Estate 15, L.L.C., a Delaware limited liability company
KND Real Estate 16, L.L.C., a Delaware limited liability company
KND Real Estate 17, L.L.C., a Delaware limited liability company
KND Real Estate 18, L.L.C., a Delaware limited liability company
KND Real Estate 19, L.L.C., a Delaware limited liability company
KND Real Estate 33, L.L.C., a Delaware limited liability company
KND Real Estate 34, L.L.C., a Delaware limited liability company
KND Real Estate 35, L.L.C., a Delaware limited liability company
KND Real Estate 36, L.L.C., a Delaware limited liability company
KND Real Estate 38, L.L.C., a Delaware limited liability company
KND Real Estate 39, L.L.C., a Delaware limited liability company
KND Real Estate 40, L.L.C., a Delaware limited liability company
KND Real Estate 48, L.L.C., a Delaware limited liability company

KND Real Estate 49, L.L.C., a Delaware limited liability company

KND Rehab Real Estate Holdings, L.L.C., a Delaware limited liability company

KND Real Estate 41, L.L.C., a Delaware limited liability company

KND Real Estate 42, L.L.C., a Delaware limited liability company

KND Real Estate 43, L.L.C., a Delaware limited liability company

KND Real Estate 44, L.L.C., a Delaware limited liability company

KND Real Estate 45, L.L.C., a Delaware limited liability company

KND Real Estate 50, L.L.C., a Delaware limited liability company

KND Real Estate 51, L.L.C., a Delaware limited liability company

Helian ASC of Northridge, Inc., a California corporation

MedEquities, Inc., a California corporation

Lafayette Health Care Center, Inc., a Georgia corporation

PersonaCare of Connecticut, Inc., a Connecticut corporation

Courtland Gardens Health Center, Inc., a Connecticut corporation

PersonaCare of Ohio, Inc., a Delaware corporation

PersonaCare of Reading, Inc., a Delaware corporation

PF Development 26, L.L.C., a Delaware limited liability company

PF Development 27, L.L.C., a Delaware limited liability company

RehabCare Group, Inc., a Delaware corporation

RehabCare Group Management Services, Inc., a Delaware corporation

Salt Lake Physical Therapy Associates, Inc., a Utah corporation

Centere Healthcare Corporation, a Delaware corporation

CHC Management Services, LLC, a Missouri limited liability company

CRH of St. Louis, LLC, a Missouri limited liability company

CRH of Lancaster, LLC, a Missouri limited liability company

CRH of Dallas, LLC, a Missouri limited liability company

CRH of Waukesha, LLC, a Missouri limited liability company

CRH of Ft. Worth, LLC, a Delaware limited liability company

CRH of Oklahoma City, LLC, a Delaware limited liability company

CRH of Cleveland, LLC, a Delaware limited liability company

CRH of Indianapolis, LLC, a Delaware limited liability company

CRH of Langhorne, LLC, a Delaware limited liability company

CRH of Springfield, LLC, a Delaware limited liability company

CRH of Memphis, LLC, a Delaware limited liability company

CRH of Madison, LLC, a Delaware limited liability company

CRH of Arlington, LLC, a Delaware limited liability company

CRH of Avon, LLC, a Delaware limited liability company

RehabCare Group East, Inc., a Delaware corporation

RehabCare Group of Texas, LLC, a Texas limited liability company

RehabCare Group of California, LLC, a Delaware limited liability company

American VitalCare, LLC, a California limited liability company

Symphony Health Services, LLC, a Delaware limited liability company

VTA Management Services, LLC, a Delaware limited liability company

VTA Staffing Services, LLC, a Delaware limited liability company

RehabCare Hospital Holdings, LLC, a Delaware limited liability company

Clear Lake Rehabilitation Hospital, LLC, a Delaware limited liability company

Lafayette Specialty Hospital, LLC, a Delaware limited liability company

Tulsa Specialty Hospital, LLC, a Delaware limited liability company

Northland LTACH, LLC, a Delaware limited liability company

Central Texas Specialty Hospital, L.L.C., a Delaware limited liability company

CTRH, L.L.C., a Delaware limited liability company

St. Luke's Rehabilitation Hospital, LLC, a Delaware limited liability company

Greater Peoria Specialty Hospital, LLC, a Delaware limited liability company

Rhode Island Specialty Hospital, LLC, a Delaware limited liability company

The Specialty Hospital, LLC, a Georgia limited liability company

Dallas LTACH, LLC, a Delaware limited liability company

Triumph Rehabilitation Hospital Northern Indiana, LLC, an Indiana limited liability company
Triumph Rehabilitation Hospital of Northeast Houston, LLC, a Delaware limited liability company
Triumph Hospital Northwest Indiana, Inc., a Missouri corporation
Triumph Healthcare Holdings, Inc., a Delaware corporation
 New Triumph Healthcare of Texas, LLC, a Texas limited liability company
 Triumph Healthcare Third Holdings, LLC, a Delaware limited liability company
 Triumph Healthcare Second Holdings, LLC, a Delaware limited liability company
 New Triumph Healthcare, Inc., a Delaware corporation
 SCCI Health Services Corporation, a Delaware corporation
 SCCI Hospital Ventures, Inc., a Delaware corporation
 SCCI Hospitals of America, Inc., a Delaware corporation
 SCCI Hospital-El Paso, Inc., a Delaware corporation
 SCCI Hospital-Mansfield, Inc., a Delaware corporation

Tucker Nursing Center, Inc., a Georgia corporation

Specialty Healthcare Services, Inc., a Delaware corporation

 Southern California Specialty Care, Inc., a California corporation

 Specialty Hospital of Cleveland, Inc., an Ohio corporation

 Specialty Hospital of Philadelphia, Inc., a Pennsylvania corporation

 Specialty Hospital of South Carolina, Inc., a South Carolina corporation

JB Thomas Hospital, Inc., a Massachusetts corporation

THC - Chicago, Inc., an Illinois corporation

 THC - North Shore, Inc., an Illinois corporation

THC - Houston, Inc., a Texas corporation

THC - Orange County, Inc., a California corporation

THC - Seattle, Inc., a Washington corporation

Transitional Hospitals Corporation of Indiana, Inc., an Indiana corporation

Transitional Hospitals Corporation of Louisiana, Inc., a Louisiana corporation

Transitional Hospitals Corporation of New Mexico, Inc., a New Mexico corporation

Transitional Hospitals Corporation of Nevada, Inc., a Nevada corporation

Transitional Hospitals Corporation of Tampa, Inc., a Florida corporation

Transitional Hospitals Corporation of Texas, Inc., a Texas corporation

Transitional Hospitals Corporation of Wisconsin, Inc., a Wisconsin corporation

Gentiva Health Services, Inc., a Delaware corporation

Odyssey HealthCare Inc., a Delaware corporation

Odyssey HealthCare Holding Company, a Delaware corporation

Odyssey HealthCare GP, LLC, a Delaware limited liability company

Odyssey HealthCare LP, LLC, a Delaware limited liability company

VistaCare, LLC, a Delaware limited liability company

Vista Hospice Care, LLC, a Delaware limited liability company

VistaCare USA, LLC, a Delaware limited liability company

FHI Health Systems, Inc., a Delaware corporation

FHI GP, Inc., a Texas corporation

FHI LP, Inc., a Nevada corporation

Gentiva Health Services Holding Corp., a Delaware corporation

Gentiva Health Services (Certified), Inc., a Delaware corporation

Gentiva Certified Healthcare Corp., a Delaware corporation

PHHC Acquisition Group, a Delaware corporation

Gilbert's Hospice Care, LLC, a Mississippi limited liability company

Gilbert's Hospice Care of Mississippi, LLC, a Mississippi limited liability company

Home Health Care Affiliates of Central Mississippi, LLC, a Mississippi limited liability company

Home Health Care Affiliates of Mississippi, Inc., a Mississippi corporation

Home Health Care Affiliates, Inc., a Mississippi corporation

Gilbert's Home Health Agency, Inc., a Mississippi corporation

Van Winkle Home Health Care, Inc., a Mississippi corporation

Gentiva Health Services (USA) LLC, a Delaware limited liability company

Gentiva Services of New York, Inc., a New York corporation

New York Healthcare Services, Inc., a New York corporation

OHS Service Corp., a Texas corporation

QC-Medi New York, Inc., a New York corporation

Quality Care-USA, Inc., a New York corporation

Gentiva Insurance Corporation, a New York corporation

Healthfield Operating Group, LLC, a Delaware limited liability company

Healthfield, LLC, a Delaware limited liability company

Chattahoochee Valley Home Care Services, LLC, a Georgia limited liability company

Chattahoochee Valley Home Health, LLC, a Georgia limited liability company

CHMG Acquisition LLC, a Georgia limited liability company

Capital Health Management Group, LLC, a Georgia limited liability company

Access Home Health of Florida, LLC, a Delaware limited liability company

Capital Care Resources, LLC, a Georgia limited liability company

Capital Care Resources of South Carolina, LLC, a Georgia limited liability company

CHMG of Atlanta, LLC, a Georgia limited liability company

CHMG of Griffin, LLC, a Georgia limited liability company

Eastern Carolina Home Health Agency, LLC, a North Carolina limited liability company

Home Health Care of Carteret County, LLC, a North Carolina limited liability company

Tar Heel Health Care Services, LLC, a North Carolina limited liability company

Healthfield Home Health, LLC, a Georgia limited liability company

Healthfield Hospice Services, LLC, a Georgia limited liability company

Healthfield of Southwest Georgia, LLC, a Georgia limited liability company

Healthfield of Statesboro, LLC, a Georgia limited liability company

Healthfield of Tennessee, LLC, a Georgia limited liability company

Mid-South Home Health, LLC, a Georgia limited liability company

Mid-South Home Health of Gadsden, LLC, a Georgia limited liability company

Total Care Home Health of Louisburg, LLC, a Georgia limited liability company

Total Care Home Health of North Carolina, LLC, a Georgia limited liability company

Total Care Home Health of South Carolina, LLC, a Georgia limited liability company

Wiregrass Hospice Care, LLC, a Georgia limited liability company

Horizon Health Network, LLC, an Alabama limited liability company

Mid-South Home Health Agency, LLC, an Alabama limited liability company

Mid-South Home Care Services, LLC, an Alabama limited liability company

Wiregrass Hospice, LLC, an Alabama limited liability company

Wiregrass Hospice of South Carolina, LLC, a Georgia limited liability company

Harden Healthcare Holdings, LLC, a Delaware limited liability company

Harden Healthcare, LLC, a Texas limited liability company

Harden HC Texas Holdco, LLC, a Texas limited liability company

Harden Clinical Services, LLC, a Texas limited liability company

Harden Healthcare Services, LLC, a Texas limited liability company

Harden Home Option, LLC, a Texas limited liability company

The Home Option, LLC, a Texas limited liability company

Lighthouse Hospice Partners, LLC, a Texas limited liability company

Harden Hospice, LLC, a Texas limited liability company

Bethany Hospice, LLC, a Delaware limited liability company

California Hospice, LLC, a Texas limited liability company

Georgia Hospice, LLC, a Texas limited liability company

Lighthouse Hospice-Coastal Bend, LLC, a Texas limited liability company

Lighthouse Hospice Management, LLC, a Texas limited liability company
Lighthouse Hospice-Metroplex, LLC, a Texas limited liability company
ABC Hospice, LLC, a Texas limited liability company
Omega Hospice, LLC, a Texas limited liability company
Lighthouse Hospice-San Antonio, LLC, a Texas limited liability company
Harden Home Health, LLC, a Delaware limited liability company
Asian American Home Care, Inc., a California corporation
First Home Health, Inc., a West Virginia corporation
Nursing Care-Home Health Agency Inc., a West Virginia corporation
Faith in Home Services, LLC, a Kansas limited liability company
Faith Home Health and Hospice, LLC, a Kansas limited liability company
Girling Health Care Services of Knoxville, Inc., a Tennessee corporation
Girling Health Care, Inc., a Texas corporation
Hawkeye Health Services, Inc., an Iowa corporation
Horizon Health Care Services, Inc., a Texas corporation
Missouri Home Care of Rolla, Inc., a Missouri corporation
American HomeCare Management Corp., a Delaware corporation
The Home Team of Kansas, LLC, a Kansas limited liability company
Voyager Hospice Care, Inc., a Delaware corporation
Hospice Care of Kansas, LLC, a Kansas limited liability company
Hospice Care of Kansas and Missouri, LLC, a Missouri limited liability company
Hospice Care of the Midwest, LLC, a Missouri limited liability company
Colorado Hospice, LLC, a Colorado limited liability company
The American Heartland Hospice Corp., a Missouri corporation

Iowa Hospice, LLC, an Iowa limited liability company

Lakes Hospice, LLC, an Iowa limited liability company

American Hospice, Inc., a Texas corporation

Chaparral Hospice, Inc., a Texas corporation

Voyager Home Health, Inc., a Delaware corporation

Alpine Home Health Care, LLC, a Colorado limited liability company

Alpine Home Health II, Inc., a Colorado corporation

Alpine Home Health, Inc., a Mississippi corporation

Alpine Resource Group, Inc., a Colorado corporation

Saturday Partners, LLC, a Colorado limited liability company

Isidora's Health Care, Inc., a Texas corporation

We Care Home Health Services, Inc., a California corporation

HomeCare Plus, Inc., an Alabama corporation

Partnerships, Joint Ventures and Non-Profits

Kindred Hospitals Limited Partnership, a Delaware limited partnership

Kindred Nursing Centers Limited Partnership, a Delaware limited partnership

Foothill Nursing Company Partnership, a California general partnership

Fox Hill Village Partnership, a Massachusetts general partnership

Starr Farm Partnership, a Vermont general partnership

Hillhaven-MSD Partnership, a California general partnership

New Triumph Healthcare, LLP, a Texas limited partnership

Northridge Surgery Center, Ltd., a California limited partnership

Northridge Surgery Center Development Ltd., a California limited partnership

RehabCare Group of Arlington, LP, a Texas limited partnership

RehabCare Group of Amarillo, LP, a Texas limited partnership

Triumph Hospital of North Houston, L.P., a Texas limited partnership

Triumph Hospital of East Houston, L.P., a Texas limited partnership

Triumph Southwest, L.P., a Texas limited partnership

Family Hospice, Ltd., a Texas limited partnership

FHI Management, Ltd., a Texas limited partnership

Odyssey HealthCare Management, LP, a Delaware limited partnership

Odyssey HealthCare Operating A, LP, a Delaware limited partnership

Voyager Acquisition, L.P., a Texas limited partnership

Odyssey HealthCare Operating B, LP, a Delaware limited partnership

Odyssey HealthCare of Augusta, LLC, a Delaware limited liability company

Odyssey HealthCare of Austin, LLC, a Delaware limited liability company

Odyssey HealthCare of Detroit, LLC, a Delaware limited liability company

Odyssey HealthCare of Fort Worth, LLC, a Delaware limited liability company

Odyssey HealthCare of Flint, LLC, a Delaware limited liability company

Odyssey HealthCare of Marion County, LLC, a Delaware limited liability company

Odyssey HealthCare of Savannah, LLC, a Delaware limited liability company

Odyssey HealthCare of St. Louis, LLC, a Delaware limited liability company

VistaCare of Boston, LLC, a Delaware limited liability company

Odyssey HealthCare of Kansas City, LLC, a Delaware limited liability company

Odyssey HealthCare of South Texas, LLC, a Delaware limited liability company

Wake Forest Baptist Health Care at Home, LLC, a North Carolina limited liability company

CTRH, L.L.C., a Delaware limited liability company

Dallas LTACH, LLC, a Delaware limited liability company

Greater Peoria Specialty Hospital, L.L.C., a Delaware limited liability company

Rhode Island Specialty Hospital, LLC, a Delaware limited liability company

St. Luke's Rehabilitation Hospital, LLC, a Delaware limited liability company

The Specialty Hospital, LLC, a Georgia limited liability company

Avon RH, LLC, a Delaware limited liability company

Beachwood RH, LLC, a Delaware limited liability company

Lancaster Rehabilitation Hospital, a Delaware limited liability company

Mercy Rehabilitation Hospital-St. Louis, LLC, a Missouri limited liability company

Mercy Rehabilitation Hospital Springfield, LLC, a Missouri limited liability company

Mercy Rehabilitation Hospital, LLC, an Oklahoma limited liability company

Rehabilitation Hospital of Wisconsin, LLC, a Delaware limited liability company

Texas Rehabilitation Hospital of Arlington, LLC, a Texas limited liability company

Texas Rehabilitation Hospital of Fort Worth, LLC, a Texas limited liability company

RWW Michigan, Inc., a Michigan corporation

Hospice of the Emerald Coast, Inc., a Florida corporation

Saint Thomas Rehabilitation Hospital, LLC, a Tennessee limited liability company

Atlantic Rehabilitation Institute, LLC, a New Jersey limited liability company

Mercy Rehabilitation Hospital, LLC, an Iowa limited liability company

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statement on Form S-3 (No. 333-196804) and Form S-8 (Nos. 333-59598, 333-62022, 333-88086, 333-116755, 333-151580, 333-174615, 333-183269, 333-197755, 333-201830, 333-201831, and 333-204550) of Kindred Healthcare, Inc. of our report dated February 28, 2017 relating to the financial statements, financial statement schedule, and the effectiveness of internal control over financial reporting, which appears in this Form 10-K.

/s/ PricewaterhouseCoopers LLP
Louisville, Kentucky
February 28, 2017

**Certification Required By Rules 13a-14(a) and 15d-14(a)
under the Securities Exchange Act of 1934**

I, Benjamin A. Breier, certify that:

1. I have reviewed this annual report on Form 10-K of Kindred Healthcare, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
 - (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
 - (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
 - (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
 - (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
 - (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 28, 2017

/s/ Benjamin A. Breier

Benjamin A. Breier

President and Chief Executive Officer

**Certification Required By Rules 13a-14(a) and 15d-14(a)
under the Securities Exchange Act of 1934**

I, Stephen D. Farber, certify that:

1. I have reviewed this annual report on Form 10-K of Kindred Healthcare, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
 - (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
 - (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
 - (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
 - (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
 - (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 28, 2017

/s/ Stephen D. Farber

Stephen D. Farber

Executive Vice President, Chief Financial Officer

Section 1350 Certifications
Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
(Subsections (a) and (b) of Section 1350, Chapter 63 of Title 18, United States Code)

Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 (subsections (a) and (b) of Section 1350, Chapter 63 of Title 18, United States Code), each of the undersigned officers of Kindred Healthcare, Inc., a Delaware corporation (the "Company"), does hereby certify, to such officer's knowledge, that:

The Annual Report on Form 10-K for the year ended December 31, 2016 (the "Form 10-K") of the Company fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934 and information contained in the Form 10-K fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: February 28, 2017

/s/ Benjamin A. Breier

Benjamin A. Breier
President and Chief Executive Officer

Date: February 28, 2017

/s/ Stephen D. Farber

Stephen D. Farber
Executive Vice President, Chief Financial Officer

**UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549**

FORM 10-K

(Mark One)

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2017

OR

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

Commission File Number: 001-14057

KINDRED HEALTHCARE, INC.

(Exact name of registrant as specified in its charter)

Delaware
(State or other jurisdiction of
incorporation or organization)

61-1323993
(I.R.S. Employer
Identification Number)

680 South Fourth Street
Louisville, Kentucky
(Address of principal executive offices)

40202-2412
(Zip Code)

(502) 596-7300

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

<u>Title of Each Class</u>	<u>Name of Each Exchange on which Registered</u>
Common Stock, par value \$0.25 per share	New York Stock Exchange

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Annual Report on Form 10-K or any amendment of this Annual Report on Form 10-K.

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer Accelerated filer Non-accelerated filer Smaller reporting company Emerging growth company

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes No

The aggregate market value of the shares of the registrant held by non-affiliates of the registrant, based on the closing price of such stock on the New York Stock Exchange on June 30, 2017, was approximately \$974,300,000. For purposes of the foregoing calculation only, all directors and executive officers of the registrant have been deemed affiliates.

As of January 31, 2018, there were 91,413,775 shares of the registrant's common stock, \$0.25 par value, outstanding.

TABLE OF CONTENTS

	<u>Page</u>
<u>PART I</u>	
Item 1. Business	5
Item 1A. Risk Factors	37
Item 1B. Unresolved Staff Comments	56
Item 2. Properties	56
Item 3. Legal Proceedings	56
Item 4. Mine Safety Disclosures	57
<u>PART II</u>	
Item 5. Market for Registrant’s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities	58
Item 6. Selected Financial Data	60
Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations	62
Item 7A. Quantitative and Qualitative Disclosures About Market Risk	90
Item 8. Financial Statements and Supplementary Data	91
Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure	91
Item 9A. Controls and Procedures	91
Item 9B. Other Information	91
<u>PART III</u>	
Item 10. Directors, Executive Officers and Corporate Governance	92
Item 11. Executive Compensation	93
Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters	93
Item 13. Certain Relationships and Related Transactions, and Director Independence	93
Item 14. Principal Accounting Fees and Services	93
<u>PART IV</u>	
Item 15. Exhibits and Financial Statement Schedules	94
Item 16. Form 10-K Summary	94

KINDRED HEALTHCARE, INC.
INDEX TO CONSOLIDATED FINANCIAL STATEMENTS
AND FINANCIAL STATEMENT SCHEDULES

	<u>Page</u>
<u>Report of Independent Registered Public Accounting Firm</u>	F-2
Consolidated Financial Statements:	
<u>Consolidated Statement of Operations for the years ended December 31, 2017, 2016 and 2015</u>	F-3
<u>Consolidated Statement of Comprehensive Loss for the years ended December 31, 2017, 2016 and 2015</u>	F-4
<u>Consolidated Balance Sheet, December 31, 2017 and 2016</u>	F-5
<u>Consolidated Statement of Equity for the years ended December 31, 2017, 2016 and 2015</u>	F-6
<u>Consolidated Statement of Cash Flows for the years ended December 31, 2017, 2016 and 2015</u>	F-7
<u>Notes to Consolidated Financial Statements</u>	F-8
<u>Quarterly Consolidated Financial Information (Unaudited)</u>	F-70
Financial Statement Schedule (a):	
<u>Schedule II – Valuation and Qualifying Accounts for the years ended December 31, 2017, 2016 and 2015</u>	F-72

(a) All other schedules have been omitted because the required information is not present or not present in material amounts.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders
of Kindred Healthcare, Inc.

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of Kindred Healthcare, Inc. and its subsidiaries as of December 31, 2017 and 2016, and the related consolidated statements of operations, comprehensive loss, equity and cash flows for each of the three years in the period ended December 31, 2017, including the related notes and financial statement schedule listed in the index appearing under Item 15(a)(2) (collectively referred to as the “consolidated financial statements”). We also have audited the Company’s internal control over financial reporting as of December 31, 2017, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2017 and 2016, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2017 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2017 based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the COSO.

Basis for Opinions

The Company’s management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in Management’s Annual Report on Internal Control over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on the Company’s consolidated financial statements and on the Company’s internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (“PCAOB”) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the consolidated financial statements included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

Definition and Limitations of Internal Control over Financial Reporting

A company’s internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company’s internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company’s assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ PRICEWATERHOUSECOOPERS LLP

Louisville, Kentucky
February 28, 2018

We have served as the Company’s auditor since 1999.

KINDRED HEALTHCARE, INC.
CONSOLIDATED STATEMENT OF OPERATIONS
(In thousands, except per share amounts)

	Year ended December 31,		
	2017	2016	2015
Revenues	\$ 6,034,123	\$ 6,292,529	\$ 6,119,218
Salaries, wages and benefits	3,318,885	3,392,263	3,233,047
Supplies	303,923	343,065	342,075
Building rent	257,516	264,306	257,221
Equipment rent	34,856	39,929	38,590
Other operating expenses	640,764	656,792	639,608
General and administrative expenses (exclusive of depreciation and amortization expense included below)	1,069,764	1,107,648	1,210,787
Other income	(3,460)	(5,066)	(2,358)
Litigation contingency expense	7,435	2,840	138,648
Impairment charges	381,179	314,729	24,757
Restructuring charges	84,861	96,126	12,618
Depreciation and amortization	104,805	131,819	129,246
Interest expense	241,411	234,612	232,351
Investment income	(3,499)	(3,108)	(2,756)
	<u>6,438,440</u>	<u>6,575,955</u>	<u>6,253,834</u>
Loss from continuing operations before income taxes	(404,317)	(283,426)	(134,616)
Provision (benefit) for income taxes	(157,116)	314,262	(51,714)
Loss from continuing operations	(247,201)	(597,688)	(82,902)
Discontinued operations, net of income taxes:			
Income (loss) from operations	(16,854)	(6,192)	30,804
Gain (loss) on divestiture of operations	(379,260)	(6,744)	1,244
Income (loss) from discontinued operations	(396,114)	(12,936)	32,048
Net loss	(643,315)	(610,624)	(50,854)
Earnings attributable to noncontrolling interests:			
Continuing operations	(42,176)	(34,847)	(26,044)
Discontinued operations	(12,861)	(18,759)	(16,486)
	<u>(55,037)</u>	<u>(53,606)</u>	<u>(42,530)</u>
Loss attributable to Kindred	<u>\$ (698,352)</u>	<u>\$ (664,230)</u>	<u>\$ (93,384)</u>
Amounts attributable to Kindred stockholders:			
Loss from continuing operations	\$ (289,377)	\$ (632,535)	\$ (108,946)
Income (loss) from discontinued operations	(408,975)	(31,695)	15,562
Net loss	<u>\$ (698,352)</u>	<u>\$ (664,230)</u>	<u>\$ (93,384)</u>
Loss per common share:			
Basic:			
Loss from continuing operations	\$ (3.31)	\$ (7.29)	\$ (1.29)
Discontinued operations:			
Income (loss) from operations	(0.34)	(0.28)	0.17
Gain (loss) on divestiture of operations	(4.33)	(0.08)	0.01
Income (loss) from discontinued operations	(4.67)	(0.36)	0.18
Net loss	<u>\$ (7.98)</u>	<u>\$ (7.65)</u>	<u>\$ (1.11)</u>
Diluted:			
Loss from continuing operations	\$ (3.31)	\$ (7.29)	\$ (1.29)
Discontinued operations:			
Income (loss) from operations	(0.34)	(0.28)	0.17
Gain (loss) on divestiture of operations	(4.33)	(0.08)	0.01
Income (loss) from discontinued operations	(4.67)	(0.36)	0.18
Net loss	<u>\$ (7.98)</u>	<u>\$ (7.65)</u>	<u>\$ (1.11)</u>
Shares used in computing loss per common share:			
Basic	87,525	86,800	84,558
Diluted	87,525	86,800	84,558
Cash dividends declared and paid per common share	\$ 0.12	\$ 0.48	\$ 0.48

See accompanying notes.

KINDRED HEALTHCARE, INC.
CONSOLIDATED STATEMENT OF COMPREHENSIVE LOSS
(In thousands)

	Year ended December 31,		
	2017	2016	2015
Net loss	\$ (643,315)	\$ (610,624)	\$ (50,854)
Other comprehensive income (loss):			
Available-for-sale securities (Note 13):			
Change in unrealized investment gains (losses)	1,399	1,636	(133)
Reclassification of gains realized in net loss	(1,451)	(1,206)	(173)
Net change	(52)	430	(306)
Interest rate swaps (Notes 1 and 15):			
Change in unrealized gains (losses)	5,225	1,755	(799)
Reclassification of ineffectiveness realized in net loss	-	-	146
Reclassification of (gains) losses realized in net loss, net of payments	(609)	411	-
Net change	4,616	2,166	(653)
Defined benefit post-retirement plan:			
Unrealized gain due to fair value adjustments	42	220	753
Income tax benefit related to items of other comprehensive income (loss)	-	1,389	125
Other comprehensive income (loss)	4,606	4,205	(81)
Comprehensive loss	(638,709)	(606,419)	(50,935)
Earnings attributable to noncontrolling interests	(55,037)	(53,606)	(42,530)
Comprehensive loss attributable to Kindred	<u>\$ (693,746)</u>	<u>\$ (660,025)</u>	<u>\$ (93,465)</u>

See accompanying notes.

KINDRED HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEET
(In thousands, except per share amounts)

	December 31, 2017	December 31, 2016
ASSETS		
Current assets:		
Cash and cash equivalents	\$ 160,254	\$ 137,061
Insurance subsidiary investments	22,546	108,966
Accounts receivable less allowance for loss of \$96,899 — 2017 and \$71,070 — 2016	1,122,532	1,172,078
Inventories	21,716	22,438
Income taxes	4,546	10,067
Assets held for sale	17,335	289,450
Other (Note 20)	60,610	63,693
	<u>1,409,539</u>	<u>1,803,753</u>
Property and equipment, at cost:		
Land	55,731	54,726
Buildings	788,879	624,021
Equipment	814,011	813,070
Construction in progress	24,344	39,781
	<u>1,682,965</u>	<u>1,531,598</u>
Accumulated depreciation	(946,986)	(912,978)
	<u>735,979</u>	<u>618,620</u>
Goodwill	2,188,566	2,427,074
Intangible assets less accumulated amortization of \$77,603 — 2017 and \$101,612 — 2016	604,338	770,108
Insurance subsidiary investments	28,988	204,929
Other (Note 20)	265,307	288,240
Total assets (a)	<u>\$ 5,232,717</u>	<u>\$ 6,112,724</u>
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	\$ 191,827	\$ 203,925
Salaries, wages and other compensation	352,179	397,486
Due to third party payors	35,321	41,320
Professional liability risks	60,767	65,284
Accrued lease termination fees	7,610	5,224
Other accrued liabilities (Note 20)	263,977	264,512
Long-term debt due within one year	14,638	27,977
	<u>926,319</u>	<u>1,005,728</u>
Long-term debt	3,146,972	3,215,062
Professional liability risks	276,829	295,311
Deferred tax liabilities	36,881	201,808
Deferred credits and other liabilities (Note 20)	497,954	353,294
Commitments and contingencies (Note 17)		
Equity:		
Stockholder's equity:		
Common stock, \$0.25 par value; authorized 175,000 shares; issued 91,454 shares — 2017 and 85,166 shares — 2016	22,864	21,291
Capital in excess of par value	1,713,179	1,710,231
Accumulated other comprehensive income	6,179	1,573
Accumulated deficit	(1,618,896)	(920,544)
	<u>123,326</u>	<u>812,551</u>
Noncontrolling interests	224,436	228,970
Total equity	<u>347,762</u>	<u>1,041,521</u>
Total liabilities (a) and equity	<u>\$ 5,232,717</u>	<u>\$ 6,112,724</u>

(a) The Company's consolidated assets as of December 31, 2017 and 2016 include total assets of variable interest entities of \$405.8 million and \$394.1 million, respectively, which can only be used to settle the obligations of the variable interest entities. The Company's consolidated liabilities as of December 31, 2017 and 2016 include total liabilities of variable interest entities of \$43.9 million and \$38.9 million, respectively. See note 1 of the notes to consolidated financial statements.

See accompanying notes.

KINDRED HEALTHCARE, INC.
CONSOLIDATED STATEMENT OF EQUITY
(In thousands)

	Attributable to Kindred stockholders						Noncontrolling interests	Total
	Shares of common stock	Par value common stock	Capital in excess of par value	Accumulated other comprehensive income (loss)	Accumulated deficit			
Balances, December 31, 2014	69,977	\$ 17,494	\$ 1,586,692	\$ (2,551)	\$ (159,768)	\$ 44,105	\$ 1,485,972	
Comprehensive loss:								
Net income (loss)					(93,384)	42,530	(50,854)	
Net unrealized investment losses, net of income taxes				(199)			(199)	
Other				118			118	
Comprehensive loss							(50,935)	
Grant of non-vested restricted stock	672	168	(168)				-	
Issuance of common stock in connection with employee benefit plans	216	54	482		(2)		534	
Shares tendered by employees for statutory tax withholdings upon issuance of common stock	(481)	(120)	(7,050)		(3,055)		(10,225)	
Stock-based compensation amortization			20,636				20,636	
Income tax benefit in connection with the issuance of common stock under employee benefit plans			3,170				3,170	
Exchange of tangible equity units, net of costs	3,668	917	(917)				-	
Contributions made by noncontrolling interests						8,132	8,132	
Distributions to noncontrolling interests						(42,458)	(42,458)	
Purchase of noncontrolling interests						153,884	153,884	
Dividends paid			(40,119)				(40,119)	
Issuance of common stock in Gentiva Merger (see Note 3)	9,740	2,435	175,021				177,456	
Balances, December 31, 2015	83,792	20,948	1,737,747	(2,632)	(256,209)	206,193	1,706,047	
Comprehensive loss:								
Net income (loss)					(664,230)	53,606	(610,624)	
Net unrealized investment gains, net of income taxes				339			339	
Other				3,866			3,866	
Comprehensive loss							(606,419)	
Grant of non-vested restricted stock	1,384	346	(346)				-	
Issuance of common stock in connection with employee benefit plans	292	73	(73)				-	
Shares tendered by employees for statutory tax withholdings upon issuance of common stock	(302)	(76)	(2,985)		(105)		(3,166)	
Stock-based compensation amortization			16,425				16,425	
Income tax benefit in connection with the issuance of common stock under employee benefit plans			435				435	
Contributions made by noncontrolling interests						17,314	17,314	
Distributions to noncontrolling interests						(45,985)	(45,985)	
Purchase of noncontrolling interests			(234)			(2,158)	(2,392)	
Dividends paid			(40,738)				(40,738)	
Balances, December 31, 2016	85,166	21,291	1,710,231	1,573	(920,544)	228,970	1,041,521	
Comprehensive loss:								
Net income (loss)					(698,352)	55,037	(643,315)	
Net unrealized investment losses, net of income taxes				(52)			(52)	
Other				4,658			4,658	
Comprehensive loss							(638,709)	
Grant of non-vested restricted stock	2,023	506	(506)				-	
Issuance of common stock in connection with employee benefit plans	151	38	(6)				32	
Shares tendered by employees for statutory tax withholdings upon issuance of common stock	(310)	(77)	(2,455)				(2,532)	
Stock-based compensation amortization			17,249				17,249	
Contributions made by noncontrolling interests						1,655	1,655	
Distributions to noncontrolling interests						(61,226)	(61,226)	
Settlements of tangible equity units	4,424	1,106	(1,106)				-	
Dividends paid			(10,228)				(10,228)	
Balances, December 31, 2017	91,454	\$ 22,864	\$ 1,713,179	\$ 6,179	\$ (1,618,896)	\$ 224,436	\$ 347,762	

See accompanying notes.

KINDRED HEALTHCARE, INC.
CONSOLIDATED STATEMENT OF CASH FLOWS
(In thousands)

	Year ended December 31,		
	2017	2016	2015
Cash flows from operating activities:			
Net loss	\$ (643,315)	\$ (610,624)	\$ (50,854)
Adjustments to reconcile net loss to net cash provided by operating activities:			
Depreciation expense	102,481	135,966	128,533
Amortization of intangible assets	14,637	23,673	29,841
Amortization of stock-based compensation costs	17,249	16,425	20,636
Amortization of deferred financing costs	17,189	15,267	13,721
Payment of capitalized lender fees related to debt amendments	(5,403)	(7,375)	(28,012)
Provision for doubtful accounts	68,284	40,804	52,460
Deferred income taxes	(164,694)	310,338	(46,632)
Impairment charges	382,447	342,559	24,757
(Gain) loss on divestiture of discontinued operations	379,260	6,744	(1,244)
Other	17,935	12,414	13,537
Change in operating assets and liabilities:			
Accounts receivable	(20,896)	(59,031)	(8,577)
Inventories and other assets	22,854	(24,226)	54,493
Accounts payable	(12,267)	26,215	(10,380)
Income taxes	10,242	4,350	30,155
Due to third party payors	(5,999)	3,692	(30,882)
Other accrued liabilities	(104,309)	(48,955)	(15,302)
Net cash provided by operating activities	<u>75,695</u>	<u>188,236</u>	<u>176,250</u>
Cash flows from investing activities:			
Routine capital expenditures	(69,806)	(96,052)	(121,931)
Development capital expenditures	(25,895)	(34,825)	(19,931)
Acquisitions, net of cash acquired	(9,650)	(78,840)	(673,547)
Acquisition deposits	-	18,489	176,511
Sale of assets, net of lease termination charges	(71,555)	25,987	8,735
Proceeds from senior unsecured notes offering held in escrow	-	-	1,350,000
Interest in escrow for senior unsecured notes	-	-	23,438
Purchase of insurance subsidiary investments	(113,661)	(97,740)	(85,222)
Sale of insurance subsidiary investments	243,616	95,488	75,075
Net change in insurance subsidiary cash and cash equivalents	133,618	877	(12,271)
Proceeds from note receivable	-	-	25,000
Net change in other investments	24,637	(32,770)	(4,620)
Other	7	(255)	10,972
Net cash provided by (used in) investing activities	<u>111,311</u>	<u>(199,641)</u>	<u>752,209</u>
Cash flows from financing activities:			
Proceeds from borrowings under revolving credit	1,369,700	1,643,300	1,740,450
Repayment of borrowings under revolving credit	(1,432,200)	(1,689,400)	(1,631,850)
Proceeds from issuance of term loan, net of discount	-	198,100	199,000
Proceeds from other long-term debt	-	750	-
Repayment of Gentiva debt	-	-	(1,177,363)
Repayment of term loan	(14,034)	(13,527)	(12,010)
Repayment of other long-term debt	(1,045)	(1,104)	(6,752)
Payment of deferred financing costs	(413)	(522)	(3,446)
Issuance of common stock in connection with employee benefit plans	32	-	534
Payment of costs associated with issuance of common stock and tangible equity units	-	-	(915)
Payment of dividend for mandatory redeemable preferred stock	(12,372)	(11,514)	(10,887)
Dividends paid	(10,228)	(40,738)	(40,119)
Contributions made by noncontrolling interests	505	14,514	2,152
Distributions to noncontrolling interests	(61,226)	(45,985)	(42,458)
Purchase of noncontrolling interests	-	(1,000)	-
Payroll tax payments for equity awards issuance	(2,532)	(3,166)	(10,225)
Net cash provided by (used in) financing activities	<u>(163,813)</u>	<u>49,708</u>	<u>(993,889)</u>
Change in cash and cash equivalents	23,193	38,303	(65,430)
Cash and cash equivalents at beginning of period	137,061	98,758	164,188
Cash and cash equivalents at end of period	<u>\$ 160,254</u>	<u>\$ 137,061</u>	<u>\$ 98,758</u>
Supplemental information:			
Interest payments	\$ 221,177	\$ 216,062	\$ 180,266
Income tax refunds	2,054	253	26,473
Rental payments to Ventas, Inc.	154,374	167,743	171,829
Issuance of common stock in Gentiva Merger (see Note 3)	-	-	177,456
Non-cash contributions made by noncontrolling interests	1,150	2,800	5,980

See accompanying notes.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1 – BASIS OF PRESENTATION

Reporting entity

Kindred Healthcare, Inc. is a healthcare services company that through its subsidiaries operates a home health, hospice, and community care business, transitional care (“TC”) hospitals (certified as long-term acute care (“LTAC”) hospitals under the Medicare program), inpatient rehabilitation hospitals (“IRFs”), and a contract rehabilitation services business across the United States (collectively, the “Company” or “Kindred”).

Basis of presentation

The consolidated financial statements include all subsidiaries that the Company controls, including variable interest entities (“VIEs”) for which the Company is the primary beneficiary. All intercompany transactions have been eliminated.

The Company has completed several transactions related to the divestiture of unprofitable hospitals and nursing centers to improve its future operating results. The Company is also currently in the process of completing the SNF Divestiture (as defined and described more fully in Note 6). For accounting purposes, the operating results of these businesses and the gains, losses or impairments associated with these transactions have been classified as discontinued operations in the accompanying consolidated statement of operations for all periods presented in accordance with the authoritative guidance in effect through December 31, 2014. Effective January 1, 2015, the authoritative guidance modified the requirements for reporting discontinued operations. A disposal is now required to be reported in discontinued operations only if the disposal represents a strategic shift that has (or will have) a major effect on the Company’s operations and financial results.

The consolidated financial statements have been prepared in accordance with United States generally accepted accounting principles (“GAAP”) and include amounts based upon the estimates and judgments of management. Actual amounts may differ from those estimates.

Recently issued accounting requirements

In February 2018, the Financial Accounting Standards Board (the “FASB”) issued authoritative guidance which permits a company to reclassify the income tax effects of the Tax Cuts and Jobs Act of 2017 (the “Tax Reform Act”) on items within accumulated other comprehensive income to retained earnings. The new guidance is effective for annual and interim periods beginning after December 15, 2018 and early adoption is permitted. The Company will not elect to early adopt and the adoption of this standard is not expected to have a material impact on the Company’s business, financial position, results of operations or liquidity.

In August 2017, the FASB issued authoritative guidance with the objective of improving the financial reporting of hedging relationships under GAAP to better portray economic results and to simplify the application of the current hedge accounting guidance. The new guidance is effective for annual and interim periods beginning after December 15, 2018 and early adoption is permitted. The adoption of this standard is not expected to have a material impact on the Company’s business, financial position, results of operations or liquidity.

In May 2017, the FASB issued authoritative guidance to provide clarity and reduce diversity in practice when accounting for changes to terms or conditions of a share-based payment award. The new guidance is effective for annual and interim periods beginning after December 15, 2017. The adoption of this standard is not expected to have a material impact on the Company’s business, financial position, results of operations or liquidity.

In January 2017, the FASB issued authoritative guidance that simplifies the measurement of goodwill impairment to a single-step test. The guidance removes step two of the goodwill impairment test, which required a hypothetical purchase price allocation. The measurement of goodwill impairment is now the amount by which a reporting unit’s carrying value exceeds its fair value, not to exceed the carrying amount of goodwill. Under the revised guidance, failing step one will always result in goodwill impairment. The new guidance is effective for annual and interim periods beginning after December 15, 2019 and early adoption is permitted. The Company adopted the new guidance on January 1, 2017 on a prospective basis. If the Company fails step one of the goodwill impairment test under the new guidance, the results could materially impact the Company’s financial position and results of operations but not its business or liquidity.

In January 2017, the FASB issued authoritative guidance that revises the definition of a business, which affects accounting for acquisitions, disposals, goodwill impairment, and consolidation. The guidance is intended to help entities evaluate whether transactions should be accounted for as acquisitions (or disposals) of assets or businesses. The revision provides a more robust framework to use in determining when a set of assets and activities is a business. The new guidance is effective for annual and interim periods beginning after December 15, 2017. The adoption of this standard is not expected to have a material impact on the Company’s business, financial position, results of operations or liquidity.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Recently issued accounting requirements (Continued)

In November 2016, the FASB issued authoritative guidance that simplifies the disclosure of restricted cash within the statement of cash flows. The guidance is intended to reduce diversity when reporting restricted cash and requires entities to explain changes in the combined total of restricted and unrestricted balances in the statement of cash flows. The Company's restricted cash totaled \$53.2 million as of December 31, 2017, comprised of \$1.7 million in other current assets, \$22.5 million in current insurance subsidiary investments and \$29.0 million in long-term insurance subsidiary investments. The Company's restricted cash totaled \$187.1 million as of December 31, 2016, comprised of \$1.9 million in other current assets, \$109.0 million in current insurance subsidiary investments and \$76.2 million in long-term insurance subsidiary investments. The new guidance should be applied using a retrospective transition method and is effective for annual and interim periods beginning after December 15, 2017. The adoption of this standard is expected to have a material impact on the presentation of the Company's consolidated statement of cash flows, but will not have an impact on the Company's financial position or liquidity.

In August 2016, the FASB issued authoritative guidance to eliminate diversity in practice related to the cash flow statement classification of eight specific cash flow issues, which include debt prepayment or extinguishment costs, maturity of a zero coupon bond, settlement of contingent consideration liabilities after a business combination, proceeds from insurance settlements and distribution from certain equity method investees. The new guidance is effective for annual and interim periods beginning after December 15, 2017. The adoption of this standard is not expected to have a material impact on the Company's consolidated statement of cash flows.

In June 2016, the FASB issued authoritative guidance for accounting for credit losses on financial instruments. The new guidance introduces an approach based on expected losses to estimate credit losses on certain types of financial instruments and modifies the impairment model for available-for-sale debt securities. The new guidance is effective for annual periods beginning after December 15, 2019 and early adoption is permitted beginning after December 15, 2018. The adoption of this standard is not expected to have a material impact on the Company's business, financial position, results of operations, and liquidity.

In February 2016, the FASB issued amended authoritative guidance on accounting for leases. The new provisions require that a lessee of operating leases recognize in the statement of financial position a liability to make lease payments (the lease liability) and a right-of-use asset representing its right to use the underlying asset for the lease term. The lease liability will be equal to the present value of lease payments, with the right-of-use asset based upon the lease liability. The classification criteria for distinguishing between finance (or capital) leases and operating leases are substantially similar to the previous lease guidance, but with no explicit bright lines. As such, operating leases will result in straight-line rent expense similar to current practice. For short term leases (term of 12 months or less), a lessee is permitted to make an accounting election not to recognize lease assets and lease liabilities, which would generally result in lease expense being recognized on a straight-line basis over the lease term. The guidance is effective for annual and interim periods beginning after December 15, 2018, and will require application of the new guidance at the beginning of the earliest comparable period presented. The Company will not elect early adoption and will apply the modified retrospective approach as required. The adoption of this standard is expected to have a material impact on the Company's financial position. The Company does not expect an impact on its business, results of operations or liquidity.

In January 2016, the FASB issued amended authoritative guidance which makes targeted improvements for financial instruments. The new provisions impact certain aspects of recognition, measurement, presentation and disclosure requirements of financial instruments. Specifically, the guidance will (1) require equity investments to be measured at fair value with changes in fair value recognized in net income, (2) simplify the impairment assessment of equity investments without readily determinable fair values, (3) eliminate the requirement to disclose the method and assumptions used to estimate fair value for financial instruments measured at amortized cost, and (4) require separate presentation of financial assets and financial liabilities by measurement category. The guidance is effective for annual and interim periods beginning after December 15, 2017, and early adoption is not permitted. The adoption of this standard is not expected to have a material impact on the Company's business, financial position, results of operations or liquidity.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION

Recently issued accounting requirements (Continued)

In May 2014, the FASB issued authoritative guidance which changes the requirements for recognizing revenue when entities enter into contracts with customers. Under these provisions, an entity will recognize revenue when it transfers promised goods or services to customers in an amount that reflects what it expects in exchange for the goods or services. It also requires more detailed disclosures to enable users of financial statements to understand the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers.

- In July 2015, the FASB finalized a one year deferral of the new revenue standard with an updated effective date for interim and annual periods beginning on or after December 15, 2017. Entities were not permitted to adopt the standard earlier than the original effective date, which was on or after December 15, 2016.
- In March 2016, the FASB finalized its amendments to the guidance in the new revenue standard on assessing whether an entity is a principal or an agent in a revenue transaction. Under these amendments, the FASB confirmed that a principal in an arrangement controls a good or service before it is transferred to a customer but revised the structure of indicators when an entity is the principal. The amendments have the same effective date and transition requirements as the new revenue standard.
- In May 2016, the FASB finalized its amendments to the guidance in the new revenue standard on contracts with customers and specifically, collectability, non-cash consideration, presentation of sales taxes, and completed contracts. The amendments are intended to reduce the risk of diversity in practice and the cost and complexity of applying certain aspects of the revenue standard. The amendments have the same effective date and transition requirements as the new revenue standard, which is effective for interim and annual periods beginning on or after December 15, 2017, with early adoption permitted on or after December 15, 2016.

The Company will adopt the guidance as of January 1, 2018 using the modified retrospective transition method, and will disclose the cumulative-effect adjustment to retained earnings in the Company's Quarterly Report on Form 10-Q for the three months ended March 31, 2018. Based upon the Company's assessment of the new guidance, it anticipates a pretax cumulative-effect adjustment to 2017 retained earnings in the range of \$12 million to \$14 million, which primarily relates to recognizing contractual revenues earlier due to variable considerations arising from the historical collectability of its private payor portfolio and other elements of revenue subject to estimation during the period of service.

In addition, the Company anticipates a reclassification of other operating expenses or general and administrative expenses to revenue in the range of \$15 million to \$20 million as a result of the provisions of the new standard in 2018. The Company estimates between \$5 million to \$8 million of these reclassifications relates to bad debt expense, while the remaining impact results from the performance obligations under the new standard.

The Company's remaining implementation efforts are focused primarily on refining the disclosure process and internal controls.

Revenues

Revenues are recorded based upon estimated amounts due from patients and third party payors for healthcare services provided, including anticipated settlements under reimbursement agreements with Medicare, Medicaid, Medicare Advantage and other third party payors. Revenues under third party agreements are subject to examination and retroactive adjustment. Provisions for estimated third party adjustments are provided in the period the related services are rendered. Differences between the amounts accrued and subsequent settlements are recorded in the periods the interim or final settlements are determined.

A summary of revenues by payor type follows (in thousands):

	Year ended December 31,		
	2017	2016	2015
Medicare	\$ 3,171,176	\$ 3,432,456	\$ 3,283,460
Medicaid	423,359	426,102	407,754
Medicare Advantage	488,115	474,597	444,695
Medicaid Managed	203,014	163,691	141,378
Other	1,835,893	1,893,486	1,962,985
	6,121,557	6,390,332	6,240,272
Eliminations	(87,434)	(97,803)	(121,054)
	<u>\$ 6,034,123</u>	<u>\$ 6,292,529</u>	<u>\$ 6,119,218</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Cash and cash equivalents

Cash and cash equivalents include highly liquid investments with an original maturity of three months or less when purchased. The Company reclassifies outstanding checks in excess of funds on deposit. As of December 31, 2017, \$41.2 million was reclassified to accounts payable and \$4.1 million was reclassified to salaries, wages and other compensation. As of December 31, 2016, \$44.0 million was reclassified to accounts payable and \$4.9 million was reclassified to salaries, wages and other compensation.

Insurance subsidiary investments

The Company maintains investments for the payment of claims and expenses related to professional liability and workers compensation risks. These investments have been categorized as available-for-sale and are reported at fair value. The fair value of publicly traded debt and equity securities and money market funds are based upon quoted market prices or observable inputs such as interest rates using either a market or income valuation approach. Since the Company's insurance subsidiary investments are restricted for a limited purpose, they are classified in the accompanying consolidated balance sheet based upon the expected current and long-term cash requirements of the limited purpose insurance subsidiary.

The Company follows the authoritative guidance related to the meaning of other-than-temporary impairment and its application to certain investments to assess whether the Company's investments with unrealized loss positions are other-than-temporarily impaired. Unrealized gains and losses, net of deferred income taxes, are reported as a component of accumulated other comprehensive income (loss). Realized gains and losses and declines in value judged to be other-than-temporary are determined using the specific identification method and are reported in the Company's accompanying consolidated statement of operations. See Note 13.

Accounts receivable

Accounts receivable consist primarily of amounts due from the Medicare and Medicaid programs, other government programs, managed care health plans, commercial insurance companies, hospital customers, individual patients and other customers. Estimated provisions for doubtful accounts are recorded to the extent it is probable that a portion or all of a particular account will not be collected.

In evaluating the collectibility of accounts receivable, the Company considers a number of factors, including the age of the accounts, changes in collection patterns, the composition of patient accounts by payor type, the status of ongoing disputes with third party payors and general industry conditions. Actual collections of accounts receivable in subsequent periods may require changes in the estimated provision for loss. Changes in these estimates are charged or credited to the results of operations in the period of change. Based upon the termination of RehabCare (as defined below) customers and litigation associated with the collection of past due accounts, the Company recorded a provision for doubtful accounts of \$23.1 million and \$12.9 million for the years ended December 31, 2017 and 2015, respectively.

The provision for doubtful accounts totaled \$45.8 million for 2017, \$19.3 million for 2016 and \$33.5 million for 2015.

Due to third party payors

The Company's TC hospitals, IRFs, home health services and hospice services are required to submit cost reports at least annually to various state and federal agencies administering the respective reimbursement programs. In many instances, interim cash payments to the Company are only an estimate of the amount due for services provided. Any overpayment to the Company arising from the completion of a cost report is recorded as a liability in the accompanying consolidated balance sheet.

Gentiva Health Services, Inc. ("Gentiva") entered into a five-year Corporate Integrity Agreement with the United States Department of Health and Human Services Office of Inspector General (the "OIG") (the "Gentiva CIA"), which became effective on February 15, 2012 and expired in February 2017. The Gentiva CIA imposed monitoring, reporting, certification, oversight and training obligations which the Company, as a result of the Gentiva Merger (as defined in Note 3), had to comply. In the event of a breach of the Gentiva CIA, the Company could have become liable for payment of certain stipulated penalties, or its Gentiva subsidiaries could have been excluded from participation in federal healthcare programs. During 2016, the Company paid stipulated penalties of \$3.1 million for the failure to fully and adequately adhere to the requirements to implement the corrective actions called for in the Gentiva CIA.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Due to third party payors (Continued)

The Company entered into a five-year corporate integrity agreement with the OIG on January 11, 2016 (the “RehabCare CIA”). The RehabCare CIA imposes monitoring, auditing (including by an independent review organization), reporting, certification, oversight, screening, and training obligations with which the Company must comply. These obligations include retention of an independent review organization to perform duties under the RehabCare CIA, which include reviewing compliance by RehabCare Group, Inc. and its subsidiaries (“RehabCare”), a therapy services company acquired by the Company on June 1, 2011, with federal program requirements and accepted medical practices, and annual reporting obligations to the OIG regarding RehabCare’s compliance with the RehabCare CIA (including corresponding certification by senior management and the Board of Directors or a committee thereof). In the event of a breach of the RehabCare CIA, the Company could become liable for payment of certain stipulated penalties, or RehabCare’s subsidiaries could be excluded from participation in federal healthcare programs. The costs associated with compliance with the RehabCare CIA could be substantial and may be greater than the Company currently anticipates.

Any breach or failure to comply with the RehabCare CIA, the imposition of substantial monetary penalties, or any suspension or exclusion from participation in federal healthcare programs, could have a material adverse effect on the Company’s business, financial position, results of operations, and liquidity.

Inventories

Inventories consist primarily of pharmaceutical and medical supplies and are stated at the lower of cost (first-in, first-out) or market.

Property and equipment

Beginning April 1, 2017, the Company changed the estimated useful life of certain information technology equipment and software based upon a detailed review of actual utilization. Following the Gentiva Merger (as defined in Note 3), the Company made significant investments in information technology and software. The actual usage and longevity of these assets supports longer lives than previously estimated. The change in estimate extended the expected useful life by one to two years depending on the asset category and has been accounted for prospectively. The impact from this change in accounting estimate was a decrease to loss from continuing operations before income taxes of approximately \$10.6 million for the year ended December 31, 2017.

Property and equipment is carried at cost less accumulated depreciation. Depreciation expense, computed by the straight-line method, was \$90.2 million for 2017, \$108.3 million for 2016 and \$99.5 million for 2015. These amounts include amortization of assets recorded under capital leases. Depreciation rates for buildings range generally from 20 to 45 years. Leasehold improvements are depreciated over their estimated useful lives or the remaining lease term, whichever is shorter. Estimated useful lives of equipment vary from five to 15 years. Depreciation expense is not recorded for property and equipment classified as held for sale. Repairs and maintenance are expensed as incurred.

The Company separates capital expenditures into two categories, routine and development, in the accompanying consolidated statement of cash flows. Purchases of routine property and equipment include expenditures at existing facilities that generally do not result in increased capacity or the expansion of services. Development capital expenditures include expenditures for the development of new facilities or the expansion of services or capacity at existing facilities.

Long-lived assets

The Company reviews the carrying value of certain long-lived assets and finite lived intangible assets with respect to any events or circumstances that indicate an impairment or an adjustment to the amortization period is necessary. If circumstances suggest that the recorded amounts cannot be recovered based upon estimated future undiscounted cash flows, the carrying values of such assets are reduced to fair value.

In assessing the carrying values of long-lived assets, the Company estimates future cash flows at the lowest level for which there are independent, identifiable cash flows. For this purpose, these cash flows are aggregated based upon the contractual agreements underlying the operation of the facility or group of facilities. Generally, an individual facility for hospitals or IRFs, skilled nursing rehabilitation services reporting unit, hospital rehabilitation services reporting unit or sites of service at a geographical location level within the Kindred at Home division are considered the lowest level for which there are independent, identifiable cash flows. However, to the extent that groups of facilities are leased under a master lease agreement in which the operations of a facility and compliance with the lease terms are interdependent upon other facilities in the agreement (including the Company’s ability to renew the lease or divest a particular property), the Company defines the group of facilities under a master lease agreement, or a renewal

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Long-lived assets (Continued)

bundle in a master lease, as the lowest level for which there are independent, identifiable cash flows. Accordingly, the estimated cash flows of all facilities within a master lease agreement, or within a renewal bundle in a master lease, are aggregated for purposes of evaluating the carrying values of long-lived assets.

Impairment charges recorded for the three years ended December 31, 2017 associated with long-lived assets are discussed in Note 5. Losses associated with the disposition or planned disposition of long-lived assets for the three years ended December 31, 2017 are discussed in Note 6.

Goodwill and intangible assets

Goodwill and indefinite-lived intangible assets primarily originated from business combinations accounted for as purchase transactions. Indefinite-lived intangible assets consist of trade names, Medicare certifications and certificates of need.

A summary of goodwill by reporting unit follows (in thousands):

	Home health	Hospice	Community care	Hospitals	Hospital rehabilitation services (2)	IRFs	RehabCare	Total
Balances, December 31, 2015	\$ 739,677	\$ 639,006	\$ 166,312	\$ 628,519	\$ 173,618	\$ 322,678	\$ -	\$ 2,669,810
Acquisitions	6,989	6,627	7,365	23,751	-	2,800	-	47,532
Dispositions	-	-	-	(29,831)	-	-	-	(29,831)
Impairment charges	-	-	-	(261,129)	-	-	-	(261,129)
Other (1)	(647)	696	(214)	-	-	857	-	692
Balances, December 31, 2016	746,019	646,329	173,463	361,310	173,618	326,335	-	2,427,074
Acquisitions	594	-	-	-	-	-	-	594
Dispositions	-	-	(2,837)	-	-	-	-	(2,837)
Impairment charges	-	-	-	(236,265)	-	-	-	(236,265)
Balances, December 31, 2017	\$ 746,613	\$ 646,329	\$ 170,626	\$ 125,045	\$ 173,618	\$ 326,335	\$ -	\$ 2,188,566
Accumulated impairment charges:								
December 31, 2016	\$ (76,082)	\$ -	\$ -	\$ (261,129)	\$ -	\$ -	\$ (153,898)	\$ (491,109)
December 31, 2017	\$ (76,082)	\$ -	\$ -	\$ (497,394)	\$ -	\$ -	\$ (153,898)	\$ (727,374)

- (1) Other consists primarily of non-cash adjustments related to acquisitions within the measurement period.
(2) This reporting unit has a negative carrying value.

In accordance with the authoritative guidance for goodwill and other intangible assets, the Company is required to perform an impairment test for goodwill and indefinite-lived intangible assets at least annually or more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. The Company performs its annual goodwill impairment test on October 1 each fiscal year for each of its reporting units.

A reporting unit is either an operating segment or one level below the operating segment, referred to as a component. When the components within the Company's operating segments have similar economic characteristics, the Company aggregates the components of its operating segments into one reporting unit. Accordingly, the Company has determined that its reporting units are home health, hospice, community care, hospitals, hospital rehabilitation services, IRFs, and RehabCare. The community care reporting unit is included in the home health operating segment of the Kindred at Home division. The hospital rehabilitation services and IRFs reporting units are both included in the Kindred Hospital Rehabilitation Services operating segment of the Kindred Rehabilitation Services division.

In January 2017, the FASB issued authoritative guidance that simplifies the measurement of goodwill impairment to a single-step test. The guidance removes step two of the goodwill impairment test, which required a hypothetical purchase price allocation. The measurement of goodwill impairment is now the amount by which a reporting unit's carrying value exceeds its fair value, not to exceed the carrying amount of goodwill. Under the revised guidance, failing step one will always result in goodwill impairment. The Company adopted the new guidance on January 1, 2017 on a prospective basis. Based upon the results of the annual impairment test for goodwill for each of the Company's reporting units at October 1, 2017, an impairment charge of \$236.3 million was recorded. See Note 5 for a discussion of goodwill impairment charges.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Goodwill and intangible assets (Continued)

The goodwill impairment test involved a two-step process at October 1, 2016. The first step was a comparison of each reporting unit's fair value to its carrying value. If the carrying value of the reporting unit is greater than its fair value, there is an indication that impairment may exist and the second step must be performed to measure the amount of impairment loss, if any. Based upon the results of the step one annual impairment test for goodwill for each of the Company's reporting units at October 1, 2016, no impairment charges were recorded in connection with the Company's annual impairment test. See Note 5 for a discussion of goodwill impairment triggering events.

Since quoted market prices for the Company's reporting units are not available, the Company applies judgment in determining the fair value of these reporting units for purposes of performing the goodwill impairment test. The Company relies on widely accepted valuation techniques, including discounted cash flow and market multiple analyses approaches, which capture both the future income potential of the reporting unit and the market behaviors and actions of market participants in the industry that includes the reporting unit. These types of analyses require the Company to make assumptions and estimates regarding future cash flows, industry-specific economic factors and the profitability of future business strategies. The discounted cash flow approach uses a projection of estimated operating results and cash flows that are discounted using a weighted average cost of capital. Under the discounted cash flow approach, the projection uses management's best estimates of economic and market conditions over the projected period for each reporting unit including growth rates in the number of admissions, patient days, reimbursement rates, operating costs, rent expense, and capital expenditures. Other significant estimates and assumptions include terminal value growth rates, changes in working capital requirements and weighted average cost of capital. The market multiple analysis estimates fair value by applying cash flow multiples to the reporting unit's operating results. The multiples are derived from comparable publicly traded companies with similar operating and investment characteristics to the reporting units.

Adverse changes in the operating environment and related key assumptions used to determine the fair value of the Company's reporting units and indefinite-lived intangible assets or declines in the value of the Company's Common Stock (as defined below) may result in future impairment charges for a portion or all of these assets. Specifically, if the rate of growth of government and commercial revenues earned by the Company's reporting units were to be less than projected, if healthcare reforms were to negatively impact the Company's business, or if recent increases in labor costs materially exceed the Company's projections in its reporting units or business segments, an impairment charge of a portion or all of these assets may be required. An impairment charge could have a material adverse effect on the Company's business, financial position and results of operations, but would not be expected to have an impact on the Company's cash flows or liquidity.

The Company's indefinite-lived intangible assets consist of trade names, Medicare certifications, and certificates of need. The fair values of the Company's indefinite-lived intangible assets are derived from current market data, including comparable sales or royalty rates, and projections at a facility, geographical location level or reporting unit, which include management's best estimates of economic and market conditions over the projected period. Significant assumptions include growth rates in the number of admissions, patient days, reimbursement rates, operating costs, rent expense, capital expenditures, terminal value growth rates, changes in working capital requirements, weighted average cost of capital and opportunity costs.

The Company performs its annual indefinite-lived intangible asset impairment tests on May 1 and October 1 each fiscal year depending on the indefinite-lived intangible asset. See Note 5 for a discussion of indefinite-lived intangible asset impairment charges recorded during the years ended December 31, 2017 and 2016 as a result of these impairment tests and other triggering events. Based upon the results of the annual impairment test for indefinite-lived intangible assets discussed above for the year ended December 31, 2015, no impairment charges were recorded.

Losses associated with the disposition or planned disposition of goodwill and indefinite-lived intangible assets for the three years ended December 31, 2017 are discussed in Note 6.

The Company's intangible assets include both finite and indefinite-lived intangible assets. The Company's intangible assets with finite lives are amortized in accordance with the authoritative guidance for goodwill and other intangible assets, such as customer relationship assets, trade names, leasehold interests and non-compete agreements, primarily using the straight-line method over their estimated useful lives ranging from two to 15 years.

Amortization expense computed by the straight-line method totaled \$14.6 million for 2017, \$23.5 million for 2016 and \$29.7 million for 2015.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Goodwill and intangible assets (Continued)

The estimated annual amortization expense for the next five years for intangible assets at December 31, 2017 follows (in thousands):

2018	\$	9,368
2019	\$	8,852
2020	\$	8,702
2021	\$	8,585
2022	\$	8,585

A summary of intangible assets at December 31 follows (in thousands):

	2017				2016			
	Cost	Accumulated amortization	Carrying value	Weighted average life	Cost	Accumulated amortization	Carrying value	Weighted average life
Non-current:								
Certificates of need (indefinite life)	\$ 314,323	\$ -	\$ 314,323		\$ 313,816	\$ -	\$ 313,816	
Medicare certifications (indefinite life)	190,306	-	190,306		202,749	-	202,749	
Trade names (indefinite life)	21,200	-	21,200		118,569	-	118,569	
Non-compete agreements	210	(84)	126	5 years	2,335	(2,130)	205	2 years
Leasehold interests	11,032	(4,212)	6,820	9 years	14,682	(3,162)	11,520	8 years
Trade names	18,580	(17,536)	1,044	4 years	18,580	(15,374)	3,206	4 years
Customer relationship assets	126,290	(55,771)	70,519	15 years	200,989	(80,946)	120,043	14 years
	<u>\$ 681,941</u>	<u>\$ (77,603)</u>	<u>\$ 604,338</u>		<u>\$ 871,720</u>	<u>\$ (101,612)</u>	<u>\$ 770,108</u>	

Insurance risks

In connection with the Insurance Restructuring in October 2017 (as defined in Note 12), the provision for loss for professional liability risks is no longer funded to the Company's wholly owned limited purpose insurance subsidiary, Cornerstone Insurance Company ("Cornerstone") and as such, according to policy, the risks are no longer discounted. Likewise, the provision for loss for workers compensation risks is no longer funded to Cornerstone. Provisions for loss for these professional liability and workers compensation risks are based upon management's best available information, including actuarially determined estimates of loss. To the extent that expected ultimate claims costs vary from historical provisions for loss, future earnings will be charged or credited. See Notes 7 and 12.

Earnings per common share

Earnings per common share are based upon the weighted average number of common shares outstanding during the respective periods. The diluted calculation of earnings per common share includes the dilutive effect of stock options, performance-based restricted shares and tangible equity units. The Company follows the provisions of the authoritative guidance for determining whether instruments granted in share-based payment transactions are participating securities for purposes of calculating earnings per common share. See Note 9.

Derivative financial instruments

The Company accounts for derivative financial instruments in accordance with the authoritative guidance for derivatives and hedging. These derivative financial instruments are recognized as assets or liabilities in the accompanying consolidated balance sheet and are measured at fair value. The Company's derivatives are designated as cash flow hedges. The Company entered into interest rate swap agreements in January 2016 and March 2014 to hedge its floating interest rate risk.

The interest rate swaps were assessed for hedge effectiveness for accounting purposes and the Company determined the interest rate swaps qualify for cash flow hedge accounting treatment at December 31, 2017 and 2016. The Company records the effective portion of the gain or loss on the derivative financial instruments in accumulated other comprehensive income (loss) as a component of stockholders' equity and records the ineffective portion of the gain or loss on the derivative financial instruments as interest expense. There was no ineffectiveness related to the interest rate swaps for the years ended December 31, 2017 and 2016. The ineffectiveness related to the interest rate swaps for the year ended December 31, 2015 was immaterial. See Note 15.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Variable interest entities

The Company follows the provisions of the authoritative guidance for determining whether an entity is a VIE. In order to determine if the Company is a primary beneficiary of a VIE for financial reporting purposes, it must consider whether it has the power to direct activities of the VIE that most significantly impact the performance of the VIE and whether the Company has the obligation to absorb losses or the right to receive returns that would be significant to the VIE. The Company consolidates a VIE when it is the primary beneficiary.

Of the Company's 19 operating IRFs, 17 are partnerships subject to an operating and management services agreement. Under GAAP, the Company determined that 14 of these 17 partnerships qualify as VIEs and concluded that the Company is the primary beneficiary in all but one partnership. The Company holds an ownership interest and acts as manager in each of the partnerships. Through the management services agreement, the Company is delegated necessary responsibilities to provide management services, administrative services and direction of the day-to-day operations. Based upon the Company's assessment of the most significant activities of the IRFs, the manager has the ability to direct the majority of those activities in 13 of these partnerships.

The analysis upon which the consolidation determination rests can be complex, can involve uncertainties, and requires judgment on various matters, some of which could be subject to different interpretations.

The carrying amounts and classifications of the assets and liabilities of the consolidated VIEs at December 31 follow (in thousands):

	2017	2016
Assets:		
Current assets:		
Cash and cash equivalents	\$ 43,734	\$ 41,681
Accounts receivable, net	47,034	33,996
Inventories	1,541	1,641
Other	2,899	2,824
	<u>95,208</u>	<u>80,142</u>
Property and equipment, net	14,160	16,736
Goodwill	275,375	275,375
Intangible assets, net	21,002	21,839
Other	6	15
Total assets	<u>\$ 405,751</u>	<u>\$ 394,107</u>
Liabilities:		
Current liabilities:		
Accounts payable	\$ 26,533	\$ 23,345
Salaries, wages and other compensation	3,092	3,160
Other accrued liabilities	4,066	3,046
Long-term debt due within one year	604	1,571
	<u>34,295</u>	<u>31,122</u>
Long-term debt	378	455
Deferred credits and other liabilities	9,235	7,357
Total liabilities	<u>\$ 43,908</u>	<u>\$ 38,934</u>

Stock option accounting

The Company recognizes compensation expense in its consolidated financial statements using a Black-Scholes option valuation model for non-vested stock options. See Note 18.

Other information

The Company has performed an evaluation of subsequent events through the date on which the financial statements were issued.

Reclassifications

Certain prior period amounts have been reclassified to conform with the current period presentation.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 2 – PLANNED ACQUISITION OF KINDRED

Merger Agreement

On December 19, 2017, the Company announced that its Board of Directors (the “Board”) had approved a definitive agreement under which the Company will be acquired by a consortium of three companies: TPG Capital (“TPG”), Welsh, Carson, Anderson & Stowe (“WCAS”) and Humana Inc. (“Humana”). Subject to the terms and conditions of an Agreement and Plan of Merger (the “Merger Agreement”) among the Company, Kentucky Hospital Holdings, LLC (“HospitalCo Parent”), Kentucky Homecare Holdings, Inc. (“Parent”) and Kentucky Homecare Merger Sub, Inc. (“Merger Sub”), Merger Sub will be merged with and into Kindred (the “Merger”), with Kindred continuing as the surviving company in the Merger (the “Surviving Entity”).

At the effective time of the Merger, each share of the Company’s common stock, par value \$0.25 per share (“Common Stock”) issued and outstanding immediately prior to the effective time of the Merger (other than shares held by Parent, HospitalCo Parent, Merger Sub or Kindred and their respective wholly owned subsidiaries (which will be cancelled) and shares that are owned by stockholders who have properly exercised and perfected a demand for appraisal rights under Delaware law), will be cancelled and converted into the right to receive \$9.00 in cash, without interest (the “Merger Consideration”).

The Merger Agreement contains customary representations, warranties and covenants for a transaction of this nature. The Merger Agreement also contains customary covenants, including, among others, covenants (i) providing for the Company and its respective subsidiaries to conduct business in all material respects in the ordinary course and not to take certain actions without Merger Sub’s consent and (ii) for each of the parties to use reasonable best efforts to cause the transactions contemplated by the Merger Agreement to be consummated. Additionally, the Merger Agreement provides for customary pre-closing covenants, including covenants not to solicit proposals relating to alternative transactions or, subject to certain exceptions, enter into discussions concerning or provide information in connection with alternative transactions, covenants to call and hold a meeting of the Company’s stockholders and a covenant to recommend that its stockholders adopt the Merger Agreement, subject to certain exceptions to permit the Company’s directors to satisfy their applicable fiduciary duties.

Consummation of the Merger is subject to various conditions, including, among others, adoption of the Merger Agreement by the requisite vote of the Company’s stockholders, the receipt of certain licensure and regulatory approvals, the expiration of the waiting period under the Hart-Scott-Rodino Antitrust Improvement Act of 1976, as amended (this condition was satisfied on February 20, 2018), the consummation of the purchase of the two remaining skilled nursing facilities from Ventas, Inc. (“Ventas”) and payment of corresponding expense reimbursement to Ventas (this condition was satisfied on December 21, 2017), the satisfaction of the closing conditions to the Separation Agreement (as defined below) and certain related entity conversions, the absence of any material adverse effect on each of the Company, its home health, hospice and community care business, and its TC hospitals, IRFs and contract rehabilitation services business, and certain other customary closing conditions.

The Merger Agreement also contains certain termination rights for the Company and Merger Sub (including if the Merger is not consummated by August 17, 2018 (the “End Date”)) and provides that upon termination of the Merger Agreement under specified circumstances, including, among others, following a change in recommendation of the Board or its termination of the Merger Agreement to enter into a written definitive agreement for a “superior proposal,” the Company will be required to pay Merger Sub a termination fee of \$29 million and reimburse the documented out-of-pocket expenses of Parent, HospitalCo Parent and certain of their affiliates in connection with the Merger Agreement (the “Parent Expenses”) up to \$10 million.

If the Merger Agreement is submitted to a vote of the Company’s stockholders and approval of the Merger Agreement is not obtained, the Company will be required to reimburse Merger Sub for the amount of the Parent Expenses, up to \$7.5 million.

Parent will be required to pay the Company a reverse termination fee of \$61.5 million, and to reimburse certain of the Company’s expenses, including the reasonable and documented out-of-pocket expenses the Company incurred in connection with the implementation of the Separation Transactions (as defined in the Separation Agreement), up to \$13.5 million, in the event the Merger Agreement is terminated (i) by the Company, subject to certain limitations set forth in the Merger Agreement, if (A) there has been a breach of a representation, warranty or covenant of Parent or Merger Sub that would cause the related closing condition to be incapable of being satisfied or cured by the End Date or, if curable, is not cured by Parent or Merger Sub by the earlier of 30 days after receipt of written notice of such breach and the End Date, (B) the conditions to Parent, HospitalCo Parent and Merger Sub’s obligations to consummate the closing have been satisfied (other than those conditions that by their terms are to be satisfied at or immediately prior to the closing, provided that such conditions are then capable of being satisfied at the closing), the Company has irrevocably confirmed to Parent in writing that the Company is prepared and able to consummate the closing, and Parent and Merger Sub fail to consummate the Merger by the later of the date the closing should have occurred and three business days following the date

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 2 – PLANNED ACQUISITION OF KINDRED (Continued)

Merger Agreement (Continued)

of the notice from the Company described above, or (ii) by the Company or Parent if the Merger has not occurred by the End Date and at the time of termination all of the conditions to Parent, HospitalCo Parent and Merger Sub's obligations to consummate the closing have been satisfied (other than those conditions that by their terms are to be satisfied by actions taken at the closing, provided that such conditions are then capable of being satisfied at the closing) other than those relating to obtaining specified licensure and regulatory approvals and/or there being any injunction or other order by a governmental entity charged with jurisdiction over the granting of such approvals.

In connection with the Merger Agreement, Parent and HospitalCo Parent have obtained equity and debt financing commitments for the transactions contemplated by the Merger Agreement and the Separation Agreement, the aggregate proceeds of which will be sufficient to consummate the transactions contemplated by the Merger Agreement and the Separation Agreement on the closing date, including the payment of any amounts required to be paid by Parent pursuant to the Merger Agreement on the closing date, the repayment of the Company's existing indebtedness, and the payment of all fees and expenses reasonably expected to be incurred in connection therewith. Pursuant to equity commitment letters executed and delivered concurrently with the Merger Agreement, subject to the terms and conditions set forth therein, Humana, TPG, WCAS and Port-aux-Choix Private Investments Inc. ("PSP"), have committed, severally but not jointly, to capitalize Parent, and TPG, WCAS and PSP have committed, severally but not jointly, to capitalize HospitalCo Parent, with the aggregate amount of the equity financing. In addition, each of Humana, TPG, WCAS and PSP have provided us limited guarantees, guaranteeing Parent's obligation to pay the reverse termination fee and certain other reimbursement obligations of the Parent and Merger Sub pursuant to the Merger Agreement.

Separation Agreement

Concurrently with the execution and delivery of the Merger Agreement, on December 19, 2017, Kindred, Parent, HospitalCo Parent, and Kentucky Hospital Merger Sub, Inc., entered into a Separation Agreement (the "Separation Agreement"), pursuant to which, promptly following the effective time of the Merger, the Surviving Entity will be separated from the Company's home health, hospice and community care services business and acquired by HospitalCo Parent.

The Separation Agreement relates to, among other things (i) certain restructuring transactions that are to take place with respect to the Company and its subsidiaries, (ii) procedures concerning the transfer of certain assets and employees used or employed in the Company's respective businesses and (iii) the allocation of costs and expenses related to the separation of the Surviving Entity from the Homecare Business (as defined in the Separation Agreement). The Separation Agreement requires, among other things, the Company to take certain actions and expend certain efforts prior to the closing of the Merger in preparation for such separation transactions.

NOTE 3 – GENTIVA MERGER

On October 9, 2014, the Company entered into an Agreement and Plan of Merger with Gentiva, providing for the Company's acquisition of Gentiva. On February 2, 2015, the Company consummated the acquisition with one of its subsidiaries merging with and into Gentiva (the "Gentiva Merger"), with Gentiva continuing as the surviving company and the Company's wholly owned subsidiary.

At the effective time of the Gentiva Merger, each share of common stock, par value \$0.10 per share, of Gentiva ("Gentiva Common Stock") issued and outstanding immediately prior to the effective time of the Gentiva Merger (other than shares held by Kindred, Gentiva and any wholly owned subsidiaries (which were cancelled) and shares owned by stockholders who properly exercised and perfected a demand for appraisal rights under Delaware law), including each deferred share unit, were converted into the right to receive (i) \$14.50 in cash (the "Gentiva Cash Consideration"), without interest, and (ii) 0.257 of a validly issued, fully paid and nonassessable share of Common Stock (the "Gentiva Stock Consideration"). The purchase price totaled \$722.3 million and was comprised of \$544.8 million of Cash Consideration and \$177.5 million of Gentiva Stock Consideration. The Company also assumed \$1.2 billion of long-term debt, which was paid off upon consummation of the Gentiva Merger.

The Company used the net proceeds from the Gentiva Financing Transactions (as defined in Note 15), to fund the Gentiva Cash Consideration, repay Gentiva's existing debt and pay related transaction fees and expenses.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 3 – GENTIVA MERGER (Continued)

Operating results for the year ended December 31, 2016 included transaction and integration costs totaling \$5.6 million, retention and severance totaling \$0.7 million, and a lease termination charge of \$0.3 million related to the Gentiva Merger. Operating results for the year ended December 31, 2015 included transaction and integration costs totaling \$37.9 million, retention and severance costs totaling \$60.3 million, a lease termination charge of \$0.8 million and financing costs totaling \$23.4 million related to the Gentiva Merger. Transaction, integration, retention and severance costs were recorded as general and administrative expenses, and the lease termination charge was recorded as building rent expense for 2016. Transaction, integration, retention and severance costs were recorded as general and administrative expenses, the lease termination charge was recorded as building rent expense and financing costs were recorded as general and administrative expenses (\$6.0 million) and as interest expense (\$17.4 million) for 2015.

A note receivable totaling \$25 million was acquired in the Gentiva Merger. The note receivable was collected in full during the third quarter of 2015 and the Company received all of the cash proceeds.

Purchase price allocation

The Gentiva Merger purchase price of \$722.3 million was allocated based upon the estimated fair value of the tangible and intangible assets, and goodwill.

The following is the Gentiva Merger purchase price allocation (in thousands):

Cash and cash equivalents	\$ 64,695
Accounts receivable	265,034
Other current assets	123,428
Property and equipment	46,732
Identifiable intangible assets:	
Certificates of need (indefinite life)	256,921
Medicare certifications (indefinite life)	94,500
Trade names (indefinite life)	22,200
Trade name	15,600
Non-compete agreements	1,820
Leasehold interests	1,439
Total identifiable intangible assets	392,480
Deferred tax assets	37,429
Other assets	74,407
Current portion of long-term debt	(53,075)
Accounts payable and other current liabilities	(319,004)
Long-term debt, less current portion	(1,124,288)
Deferred tax liabilities	(47,748)
Other liabilities	(126,088)
Noncontrolling interests	(3,992)
Total identifiable net assets	(669,990)
Goodwill	1,392,271
Net assets	<u>\$ 722,281</u>

The fair value allocation was measured primarily using a discounted cash flows methodology, which is considered a Level 3 input (as described in Note 21).

The value of gross contractual accounts receivable before determining uncollectable amounts totaled \$278.9 million. Accounts estimated to be uncollectable totaled \$13.9 million.

The weighted average life of the definite lived intangible assets consisting primarily of a trade name was three years.

The aggregate goodwill arising from the Gentiva Merger is based upon the expected future cash flows of the Gentiva operations, which reflect both growth expectations and cost savings from combining the operations of the Company and Gentiva. Goodwill is not amortized and is not deductible for income tax purposes. Goodwill was assigned to the Company's home health reporting unit (\$612.2 million), hospice reporting unit (\$614.0 million) and community care reporting unit (\$166.1 million).

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 4 – OTHER ACQUISITIONS

The following is a summary of the Company’s other acquisition activities. The operating results of the acquired businesses have been included in the accompanying consolidated financial statements of the Company from the respective acquisition dates. The purchase price of acquired businesses and acquired leased facilities resulted from negotiations with each of the sellers that were based upon both the historical and expected future cash flows of the respective businesses and real estate values. The majority of these acquisitions were financed through operating cash flows and borrowings under the Company’s ABL Facility (as defined in Note 15). Unaudited pro forma financial data related to the acquired businesses have not been presented because the acquisitions are not material, either individually or in the aggregate, to the Company’s consolidated financial statements.

<u>Acquisitions</u>	<u>Allocation of purchase price</u>						<u>Total purchase price, net of cash received</u>
	<u>Accounts receivable</u>	<u>Property and equipment</u>	<u>Goodwill</u>	<u>Identifiable intangible assets</u>	<u>Other assets</u>	<u>Deferred income taxes and other liabilities</u>	
Year ended December 31, 2017:							
Home health acquisitions	\$ -	\$ -	\$ 594	\$ 6,056	\$ -	\$ -	\$ 6,650
Acquisition of previously leased real estate	-	3,000	-	-	-	-	3,000
	<u>\$ -</u>	<u>\$ 3,000</u>	<u>\$ 594</u>	<u>\$ 6,056</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 9,650</u>
Year ended December 31, 2016:							
Home health and hospice acquisitions (a)	\$ 989	\$ -	\$ 19,557	\$ 56,993	\$ -	\$ -	\$ 77,539
Acquisition of TC hospitals from Select (defined below)	-	10,191	23,751	17,731	749	5,850	46,572
Home-based primary care acquisition	-	-	1,424	376	-	-	1,800
IRF acquisitions	-	-	2,800	1,129	-	2,800	1,129
Other	(3,287)	-	692	-	21	(2,574)	-
	<u>\$ (2,298)</u>	<u>\$ 10,191</u>	<u>\$ 48,224</u>	<u>\$ 76,229</u>	<u>\$ 770</u>	<u>\$ 6,076</u>	<u>\$ 127,040</u>
Year ended December 31, 2015:							
Acquisition of Centerre (defined below)	\$ 28,525	\$ 15,122	\$ 265,737	\$ 23,512	\$ 21,135	\$ 174,766	\$ 179,265
Home-based primary care acquisitions	1,410	47	9,991	2,112	-	1,408	12,152
Home health acquisition	-	-	155	1,845	-	-	2,000
Other	-	-	5,980	-	-	5,980	-
	<u>\$ 29,935</u>	<u>\$ 15,169</u>	<u>\$ 281,863</u>	<u>\$ 27,469</u>	<u>\$ 21,135</u>	<u>\$ 182,154</u>	<u>\$ 193,417</u>

(a) Outstanding accounts receivable owed to the Company totaling \$9.0 million was used as consideration for acquiring a hospice business.

The fair value of each of the acquisitions noted above was measured primarily using discounted cash flow methodologies which are considered Level 3 inputs (as described in Note 21).

During the year ended December 31, 2017, the Company acquired a TC hospital building formerly leased from Ventas. The Company is currently marketing the building for sale and the net book value, which approximates fair value, is reported in other long-term assets as of December 31, 2017.

In 2016, the Company acquired five TC hospitals (233 licensed beds) operated by Select Medical Holdings Corporation (“Select”) and sold three of its TC hospitals (255 licensed beds) to Select. The Company paid Select \$7.4 million, of which \$6.0 million was in lieu of selling another TC hospital to Select. See Note 6.

On January 1, 2015, the Company completed the acquisition of Centerre Healthcare Corporation (“Centerre”) for a purchase price of approximately \$195 million in cash. The Company paid approximately \$4 million in cash for a working capital settlement. Centerre operated 11 IRFs with 614 beds through partnerships.

For the years ended December 31, 2016 and 2015, the Company incurred \$8.7 million and \$109.1 million, respectively, in transaction costs. Transaction costs related to the Gentiva Merger incurred for the years ended December 31, 2016, and 2015 totaled \$6.3 million and \$104.2 million, respectively. These costs were charged to general and administrative expenses for the periods incurred.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 5 – IMPAIRMENT CHARGES

During the fourth quarter of 2017, the Company recorded a hospital division reporting unit goodwill impairment charge of \$236.3 million in connection with its annual impairment test performed as of October 1, 2017. The impairment was required after cash flow projections and related mitigation strategies were refined after completing the first full year of operations under LTAC Legislation (as defined below). The refinement of the projections and mitigation strategies were finalized over the last three months of 2017 in connection with the preparation of the Company's annual budget for 2018. The Company also tested the carrying value of its hospital division intangible assets and property and equipment and determined impairment charges of \$3.2 million for a Medicare license and \$0.8 million for property and equipment were also necessary. The fair value of the assets was measured using Level 3 inputs, such as operating cash flows, market data and replacement cost factoring in depreciation, economic obsolescence and inflation trends.

During the fourth quarter of 2017, the Company also recorded an asset impairment charge of \$3.5 million related to previously acquired home health and hospice certificates of need as part of the annual indefinite-lived intangible assets impairment review at October 1, 2017. The fair value of the certificates of need was measured using Level 3 inputs, such as operating cash flows.

During the fourth quarter of 2017, the Company also recorded asset impairment charges of \$1.1 million related to property and equipment of the planned sale of two hospitals. The fair value of the property and equipment was measured using Level 3 inputs, primarily replacement cost and a pending offer.

During the year ended December 31, 2017, the Company recorded asset impairment charges of \$134.6 million related to the previously acquired RehabCare trade name (\$97.4 million) and customer relationship intangible asset (\$37.2 million) due to the expected loss of affiliated contracts related to the SNF Divestiture and cancellation of non-affiliated contracts. The fair value of the trade name was measured using Level 3 inputs, such as projected revenues and royalty rate. The fair value of the customer relationship intangible asset was measured using Level 3 inputs, such as discounted projected future operating cash flows.

During the year ended December 31, 2017, the Company also recorded asset impairment charges of \$1.3 million related to a hospital certificate of need (\$0.7 million) and a Medicare certification for an IRF (\$0.6 million) after completing the annual indefinite-lived intangible assets impairment review at May 1, 2017. The fair value of the certificate of need was measured using Level 3 inputs, such as operating cash flows. The fair value of the Medicare certification was measured using a pending offer, a Level 3 input.

On October 1, 2016, the Company completed the sale of 12 TC hospitals (the "Hospitals") to a group of entities operating under the name "Curahealth", which are affiliates of a private investment fund sponsored by Nautic Partners, LLC (the "Curahealth Disposal"). In connection with (1) the Curahealth Disposal, (2) the closure of three TC hospitals in the third quarter of 2016, (3) a reduction in revenues associated with revenue rate reductions announced by the Centers for Medicare and Medicaid Services ("CMS") on August 2, 2016, (4) continued increases in labor costs during 2016, and (5) a refinement of the impact of LTAC Legislation that became effective for the majority of the Company's TC hospitals on September 1, 2016 (collectively, the "Hospital Division Triggering Event"), the Company was required to assess the recoverability of the hospital division reporting unit goodwill in the third quarter of 2016.

This goodwill impairment test involved a two-step process at October 1, 2016. The first step was a comparison of the reporting unit's fair value to its carrying value. To determine the fair value of the hospital division reporting unit, the Company used a combination of an income approach and a market approach to calculate the fair value of the reporting unit. The discounted cash flow that served as the primary basis for the income approach was based upon the hospital division's financial forecast of revenue, gross profit margins, operating costs and cash flows. As a result of the Hospital Division Triggering Event, the Company concluded that the carrying value of the hospital division reporting unit exceeded its estimated fair value. The second step of the test was then performed to measure the impairment loss, a process which compares the implied fair value of goodwill to the implied fair value for the reporting unit. The Company determined that a goodwill impairment charge aggregating \$261.1 million was necessary for the three months ended September 30, 2016. The Company also assessed the recoverability of the hospital division intangible assets and property and equipment and concluded a property and equipment impairment charge of \$3.2 million was necessary. The fair value of the assets was measured using Level 3 inputs such as operating cash flows, market data and replacement cost factoring in depreciation, economic obsolescence and inflation trends.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 5 – IMPAIRMENT CHARGES (Continued)

During the year ended December 31, 2016, the Hospitals met assets held for sale criteria and were subsequently sold to Curahealth on October 1, 2016. The Company recorded impairment charges in connection with the sale aggregating \$33.0 million, of which \$19.7 million was related to property and equipment, and \$13.3 million was related to goodwill and other intangible assets. The fair value of the assets was measured using a Level 3 input of the then pending offer. In addition, in the first quarter of 2016, the Company also recorded a property and equipment impairment charge of \$7.8 million under the held and used accounting model related to the planned Curahealth Disposal. The fair value of property and equipment in the first quarter of 2016 was measured using Level 3 inputs, primarily replacement costs.

During the year ended December 31, 2016, the Company recorded an asset impairment charge of \$2.6 million related to the sale of a hospital division medical office building. The fair value of the property was measured using a Level 3 input of the offer pending at June 30, 2016. The property was subsequently sold during the third quarter of 2016.

The Company determined that the sale of three TC hospitals to Select during the second quarter of 2016 was an impairment triggering event in the hospital reporting unit. The Company tested the recoverability of the hospital reporting unit goodwill and determined that goodwill was not impaired.

As part of the annual indefinite-lived intangible assets impairment review at October 1, 2016, an impairment charge of \$3.6 million was recorded related to previously acquired home health and hospice Medicare certifications, certificates of need and a trade name. The fair value of the assets was measured using Level 3 inputs, such as projected revenues and operating cash flows. As part of the impairment review at May 1, 2016, an impairment charge of \$3.5 million was recorded related to certificates of need for two hospitals. The fair value of the certificates of need was measured using Level 3 inputs, such as operating cash flows.

In connection with the preparation of the Company's operating results for the third quarter of 2015, the Company determined that the impact of the regulatory changes announced on July 31, 2015 as part of the Pathway for SGR Reform Act of 2013 (the "SGR Reform Act") related to the Company's hospital reporting unit was an impairment triggering event. As part of the SGR Reform Act, Congress adopted various legislative changes impacting LTAC hospitals (the "LTAC Legislation"). The LTAC Legislation created new Medicare patient criteria and payment rules for LTAC hospitals. The Company tested the recoverability of its hospital reporting unit goodwill and determined that goodwill was not impaired.

During the fourth quarter of 2015, the Company recorded an asset impairment charge of \$18.0 million related to the previously acquired RehabCare trade name due to the cancellation of contracts associated with one large customer in the fourth quarter of 2015 and a reduction in projected revenues in 2016. The fair value of the trade name was measured using Level 3 inputs such as projected revenues and the industry specific royalty rate.

During the year ended December 31, 2015, the Company recorded an asset impairment charge of \$6.7 million related to previously acquired home health and hospice trade names after the decision in the first quarter of 2015 to rebrand to the Kindred at Home trade name. The fair value of the trade names was measured using Level 3 unobservable inputs, primarily economic obsolescence.

Each of the impairment charges discussed above reflects the amount by which the carrying value of the assets exceeded its estimated fair value at each impairment date.

All of the previously mentioned charges were recorded as impairment charges in the accompanying consolidated statement of operations for all periods. None of the impairment charges impacted the Company's cash flows or liquidity.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 6 – DIVESTITURES

Continuing operations

During 2017, the Company closed seven TC hospitals and 16 home health and hospice locations and recorded write-offs of property and equipment of \$2.9 million, indefinite-lived intangible assets of \$12.2 million, leasehold assets of \$2.4 million and lease termination charges of \$33.4 million.

During 2017, the Company sold four community care facilities for \$3.6 million in cash and sold a building within the Kindred at Home division for \$0.8 million in cash.

During 2016, the Company closed three TC hospitals and seven home health and hospice locations and recorded write-offs of property and equipment of \$7.1 million, indefinite-lived intangible assets of \$8.7 million and leasehold liabilities of \$5.2 million.

During 2015, the Company either sold or closed 22 home health and hospice locations and recorded write-offs of property and equipment of \$1.4 million, indefinite-lived intangible assets of \$8.9 million and goodwill of \$2.6 million, which was based upon the relative fair value of the sold home health and hospice locations.

All of the previously mentioned charges were recorded as restructuring charges in the accompanying consolidated statement of operations for all periods. See Note 8.

During 2016, the Company also completed the Curahealth Disposal for \$21.0 million in net cash proceeds, the facility swap with Select and sold a hospital division medical office building for \$3.7 million. See Notes 4 and 5.

Discontinued operations

Skilled nursing facility business exit

On June 30, 2017, the Company entered into a definitive agreement with BM Eagle Holdings, LLC, a joint venture led by affiliates of BlueMountain Capital Management, LLC (“BlueMountain”), under which the Company agreed to sell its skilled nursing facility business for \$700 million in cash (the “SNF Divestiture”). The SNF Divestiture included 89 nursing centers with 11,308 licensed beds and seven assisted living facilities with 380 licensed beds in 18 states. During 2017, the Company completed the sale of 81 skilled nursing facilities and five assisted living facilities on various dates for gross sales proceeds of \$664.2 million.

As previously disclosed, 36 of the skilled nursing facilities were previously leased from Ventas (the “Ventas Properties”). The Company had an option to acquire the real estate of the Ventas Properties for aggregate consideration of \$700 million, which the Company exercised as it closed on the sale of the Ventas Properties in connection with the SNF Divestiture during 2017. On each respective closing date, the Company paid Ventas the allocable portion of the \$700 million purchase price for the Ventas Properties and Ventas conveyed the real estate for the applicable Ventas Property to BlueMountain or its designee. The Company, through an escrow agent, paid Ventas \$647.4 million for 34 of the Ventas Properties in connection with the closings that occurred during 2017. Additionally, the Company paid \$52.6 million to an escrow agent, who paid Ventas, for two facilities to be sold in 2018. The \$76.0 million difference between the \$640.9 million net cash proceeds and \$716.9 million paid to Ventas and another landlord is included in the sale of assets in investing activities in the accompanying consolidated statement of cash flows.

The Company has previously announced that it has reached an agreement with BlueMountain and the relevant landlord to close five leased facilities in Massachusetts. None of the original purchase price with BlueMountain was allocated to these five facilities. The Company has transferred the day-to-day operations of these facilities to a third party and expects the closing of these facilities will be completed in the second quarter of 2018.

The completion of the remainder of the sales is subject to customary conditions to closing, including the receipt of all licensure, regulatory and other approvals. The Company expects that the remainder of the sales will occur in phases as regulatory and other approvals are received. The Company expects that all of the closings will be completed during 2018.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 6 – DIVESTITURES (Continued)

Discontinued operations (Continued)

Skilled nursing facility business exit (Continued)

In accordance with authoritative guidance for assets held for sale and discontinued operations accounting, the skilled nursing facility business is reported as assets held for sale and was moved to discontinued operations for all periods presented.

During 2017, the Company recorded \$379.4 million of pretax charges related to the SNF Divestiture, including a \$265.5 million lease termination charge, \$76.3 million of transaction and other costs, a \$17.9 million loss on sale-leaseback transaction, and \$19.7 million of retention costs. During 2016, the Company recorded \$7.0 million of pretax charges related to the SNF Divestiture, including \$3.0 million of transaction costs and \$4.0 million of retention costs.

In connection with the SNF Divestiture, the Company entered into an interim management agreement in the third quarter of 2017 with certain affiliates of BlueMountain in the state of California whereby the Company would lease its license of certain operations to such affiliates until licensure approval is obtained. Because the Company has continuing involvement in the business through purveying certain rights of ownership of the assets while under the interim management agreement and license sublease, the Company does not meet the requirements for a sale-leaseback transaction as described in ASC 840-40, *Leases - Sale-Leaseback Transactions*. Under the failed-sale-leaseback accounting model, the Company is deemed under GAAP to still own certain real estate assets sold to BlueMountain, which the Company must continue to reflect in its consolidated balance sheet and depreciate over the assets' remaining useful life. The Company also must treat a portion of the pretax cash proceeds from the SNF Divestiture as though it were the result of a \$140.8 million other long-term liability financing obligation in its accompanying consolidated balance sheet, and also must defer a \$17.9 million gain associated with some of these assets until continuing involvement ceases. The lease will terminate upon licensure approval, at which time the Company will cease to recognize the remaining other long-term liability financing obligation, as well as the remaining net book value of the real estate assets and will recognize the gain.

Other discontinued operations

The Company recorded a loss on divestiture of \$4.6 million for the year ended December 31, 2017, related to the sale of 15 non-strategic hospitals and one nursing center to an affiliate of Vibra Healthcare, LLC in 2013. The loss on divestiture related to an allowance for the settlement of disposed working capital under the terms of the sale agreement.

On December 27, 2014, the Company entered into an agreement with Ventas to transition the operations under the leases for nine non-strategic nursing centers (the "2014 Expiring Facilities"). Each lease terminated when the operation of such nursing center was transferred to a new operator. During 2015, the Company transferred the operations of seven of the 2014 Expiring Facilities and recorded a gain on divestiture of \$2.0 million. The two remaining facilities were transferred during 2016 and the Company recorded a gain on divestiture of \$0.3 million. For accounting purposes, the 2014 Expiring Facilities qualified as assets held for sale. Under the terms of the agreement to transition operations of the 2014 Expiring Facilities, the Company incurred a \$40 million termination fee in exchange for early termination of the leases, which was paid to Ventas in January 2015. The early termination fee was accrued as rent expense in discontinued operations in 2014.

NOTE 7 – DISCONTINUED OPERATIONS

In accordance with the authoritative guidance for the impairment or disposal of long-lived assets, the divestiture of unprofitable businesses discussed in Notes 1 and 6 have been accounted for as discontinued operations. Accordingly, the results of operations of these businesses for all periods presented and the gains, losses or impairments related to these divestitures have been classified as discontinued operations, net of income taxes, in the accompanying consolidated statement of operations based upon the authoritative guidance which was in effect through December 31, 2014. Effective January 1, 2015, the authoritative guidance modified the requirements for reporting discontinued operations. A disposal is now required to be reported in discontinued operations only if the disposal represents a strategic shift that has (or will have) a major effect on the Company's operations and financial results. At December 31, 2017, the Company had five nursing centers held for sale classified as discontinued operations.

In June 2017, the Company entered into a definitive agreement regarding the SNF Divestiture. In connection with the SNF Divestiture, the results of operations of the skilled nursing facility business, which previously were reported in the nursing center division, and the gains or losses associated with the SNF Divestiture, have been classified as discontinued operations for all periods presented. In addition, direct overhead and the profits from applicable RehabCare contracts servicing the Company's skilled nursing facility business that were not retained with new operators were moved to discontinued operations for all periods presented. The

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 7 – DISCONTINUED OPERATIONS (Continued)

Company has reclassified certain retained businesses and expenses previously reported in the nursing center division to other business segments, including hospital-based sub-acute units and a skilled nursing facility to the hospital division and a small therapy business to the Kindred Hospital Rehabilitation Services operating segment for all periods presented. See Note 6.

The following table summarizes (in thousands) the SNF Divestiture liability activity (included in current liabilities) during the two years ended December 31, 2017, which does not include non-cash charges of \$14.9 million related to other costs for the year ended December 31, 2017:

	Retention	Transaction and other costs	Lease Termination costs	Total
Liability balance at December 31, 2015	\$ -	\$ -	\$ -	\$ -
Expense	4,042	2,997	12,777	19,816
Payments	(122)	(2,577)	-	(2,699)
Other	-	-	-	-
Liability balance at December 31, 2016	3,920	420	12,777	17,117
Expense	19,698	61,345	265,539	346,582
Payments	(18,182)	(56,165)	(278,316)	(352,663)
Other	-	-	-	-
Liability balance at December 31, 2017	<u>\$ 5,436</u>	<u>\$ 5,600</u>	<u>\$ -</u>	<u>\$ 11,036</u>

A summary of discontinued operations follows (in thousands):

	Year ended December 31,		
	2017	2016	2015
Revenues	\$ 733,504	\$ 1,038,770	\$ 1,087,423
Salaries, wages and benefits	287,641	383,526	391,898
Supplies	31,496	43,374	45,938
Building rent	62,819	80,881	83,630
Equipment rent	6,203	7,575	7,816
Other operating expenses	218,555	288,856	297,115
General and administrative expenses	130,543	181,634	192,677
Other income	(709)	(606)	(683)
Impairment charges	1,268	27,830	-
Restructuring charges	-	4,010	352
Depreciation and amortization	12,313	27,820	29,128
Interest expense	21	50	48
Investment income	(63)	(57)	(64)
	<u>750,087</u>	<u>1,044,893</u>	<u>1,047,855</u>
Income (loss) from operations before income taxes	(16,583)	(6,123)	39,568
Provision for income taxes	271	69	8,764
Income (loss) from operations	(16,854)	(6,192)	30,804
Gain (loss) on divestiture of operations	(379,260)	(6,744)	1,244
Income (loss) from discontinued operations	(396,114)	(12,936)	32,048
Earnings attributable to noncontrolling interests	(12,861)	(18,759)	(16,486)
Income (loss) attributable to Kindred	<u>\$ (408,975)</u>	<u>\$ (31,695)</u>	<u>\$ 15,562</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 7 – DISCONTINUED OPERATIONS (Continued)

The following table sets forth certain discontinued operations data by business segment (in thousands):

	Year ended December 31,		
	2017	2016	2015
Revenues:			
Nursing center division	\$ 731,609	\$ 1,036,066	\$ 1,085,055
Hospital division	1,895	2,704	2,368
	<u>\$ 733,504</u>	<u>\$ 1,038,770</u>	<u>\$ 1,087,423</u>
Segment adjusted operating income:			
Nursing center division	\$ 63,143	\$ 139,840	\$ 159,558
Hospital division	2,835	2,146	920
	<u>\$ 65,978</u>	<u>\$ 141,986</u>	<u>\$ 160,478</u>
Rent:			
Nursing center division:			
Building rent	\$ 60,942	\$ 79,018	\$ 81,653
Equipment rent	6,203	7,575	7,804
	<u>\$ 67,145</u>	<u>\$ 86,593</u>	<u>\$ 89,457</u>
Hospital division:			
Building rent	\$ 1,877	\$ 1,863	\$ 1,977
Equipment rent	-	-	12
	<u>\$ 1,877</u>	<u>\$ 1,863</u>	<u>\$ 1,989</u>
Totals:			
Building rent	\$ 62,819	\$ 80,881	\$ 83,630
Equipment rent	6,203	7,575	7,816
	<u>\$ 69,022</u>	<u>\$ 88,456</u>	<u>\$ 91,446</u>
Depreciation and amortization:			
Nursing center division	\$ 12,313	\$ 27,820	\$ 29,128
Hospital division	-	-	-
	<u>\$ 12,313</u>	<u>\$ 27,820</u>	<u>\$ 29,128</u>

A summary of the net assets held for sale follows (in thousands):

	December 31, 2017	December 31, 2016
Long-term assets:		
Property and equipment, net	\$ 15,711	\$ 259,966
Intangible assets, net	-	20,127
Other	1,624	9,357
	<u>17,335</u>	<u>289,450</u>
Current liabilities (included in other accrued liabilities)	(417)	-
	<u>\$ 16,918</u>	<u>\$ 289,450</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 8 – RESTRUCTURING CHARGES

The Company has initiated various restructuring activities whereby it has incurred costs associated with reorganizing its operations, including the divestiture, swap, closure and consolidation of facilities and branches, reduced headcount and realigned operations in order to improve operations, cost efficiencies and capital structure in response to changes in the healthcare industry, increasing leverage and to partially mitigate reductions in reimbursement rates from third party payors. The costs associated with these activities are reported as restructuring charges in the accompanying consolidated statement of operations and would have been recorded as general and administrative expense or rent expense if not classified as restructuring charges.

The following table sets forth the restructuring charges incurred by business segment (in thousands):

	Year ended December 31,		
	2017	2016	2015
Kindred at Home:			
Home health	\$ 8,036	\$ 4,947	\$ 7,335
Hospice	4,713	2,822	4,386
	12,749	7,769	11,721
Hospital division	53,423	81,779	897
Kindred Rehabilitation Services:			
Kindred Hospital Rehabilitation Services	-	128	-
RehabCare	-	586	-
	-	714	-
Support center	18,689	5,864	-
	<u>\$ 84,861</u>	<u>\$ 96,126</u>	<u>\$ 12,618</u>

Restructuring Activities

Planned Acquisition of Kindred

During the fourth quarter of 2017, the Company announced that the Board had approved the Merger Agreement as described in Note 2. The costs incurred in 2017 related to the Merger Agreement include merger costs and a lease amendment fee and are expected to be substantially completed in 2018.

The composition of the restructuring costs that the Company has incurred for these restructuring initiatives is as follows (in thousands):

	Year ended December 31,		
	2017	2016	2015
Merger costs	\$ 9,989	-	-
Lease amendment fee paid to Ventas	5,000	-	-
	<u>\$ 14,989</u>	<u>\$ -</u>	<u>\$ -</u>

The following table (in thousands) summarizes the Merger restructuring liability activity (included in other accrued liabilities):

	Lease		Total
	Merger costs	amendment fee	
Liability balance at December 31, 2016	\$ -	\$ -	\$ -
Expense	9,989	5,000	14,989
Payments	(2,082)	(5,000)	(7,082)
Liability balance at December 31, 2017	<u>\$ 7,907</u>	<u>\$ -</u>	<u>\$ 7,907</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 8 – RESTRUCTURING CHARGES (Continued)

Restructuring Activities (Continued)

LTAC Hospital Portfolio Repositioning 2017 Plan

During the third quarter of 2017, the Company approved phase two of the LTAC hospital portfolio repositioning plan that incorporated the closure and conversion of certain LTAC hospitals as part of its mitigation strategies in response to new patient criteria for LTAC hospitals under the LTAC Legislation. The activities related to the LTAC hospital portfolio repositioning 2017 plan are expected to be substantially completed by the end of 2018.

The composition of the restructuring charges that the Company has incurred for these activities is as follows (in thousands):

	Year ended December 31,		
	2017	2016	2015
Lease termination costs	\$ 32,171	\$ -	\$ -
Facility closure costs	244	-	-
Severance	4,892	-	-
Asset write-offs	10,230	-	-
	<u>\$ 47,537</u>	<u>\$ -</u>	<u>\$ -</u>

The following table (in thousands) summarizes the Company's LTAC hospital portfolio repositioning 2017 plan liability activity (included in current liabilities and deferred credits and other liabilities) during the year ended December 31, 2017, which does not include non-cash charges of \$10.2 million related to asset write-offs:

	Lease	Severance	Total
	termination costs		
Liability balance at December 31, 2016	\$ -	\$ -	\$ -
Expense	32,171	4,892	37,063
Payments	(526)	(4,892)	(5,418)
Liability balance at December 31, 2017	<u>\$ 31,645</u>	<u>\$ -</u>	<u>\$ 31,645</u>

LTAC Hospital Portfolio Repositioning 2016 Plan

During the first quarter of 2016, the Company approved LTAC hospital portfolio repositioning 2016 plan that incorporated the divestiture, swap or closure of certain LTAC hospitals as part of its mitigation strategies to prepare for new patient criteria for LTAC hospitals under the LTAC Legislation. The activities related to the LTAC hospital portfolio repositioning 2016 plan were substantially completed during 2016.

The composition of the restructuring charges that the Company has incurred for these activities is as follows (in thousands):

	Year ended December 31,		
	2017	2016	2015
Lease termination costs	\$ 4,599	\$ 57,833	\$ 207
Facility closure costs and gain on disposal	232	(148)	-
Asset write-offs	1,055	20,867	167
Severance	-	3,227	523
Transaction costs	-	2,414	-
	<u>\$ 5,886</u>	<u>\$ 84,193</u>	<u>\$ 897</u>

The following table (in thousands) summarizes the Company's LTAC hospital portfolio repositioning 2016 plan liability activity (included in current liabilities and deferred credits and other liabilities) for the two years ended December 31, 2017, which does not include non-cash charges of \$1.1 million and \$20.9 million related to asset write-offs in 2017 and 2016, respectively:

	Lease termination	Severance and	Total
	costs	transaction costs	
Liability balance at December 31, 2015	\$ -	\$ -	\$ -
Expense	50,377	5,641	56,018
Payments	(9,728)	(5,626)	(15,354)
Liability balance at December 31, 2016	40,649	15	40,664
Expense	4,599	-	4,599
Payments	(11,303)	(15)	(11,318)
Liability balance at December 31, 2017	<u>\$ 33,945</u>	<u>\$ -</u>	<u>\$ 33,945</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 8 – RESTRUCTURING CHARGES (Continued)

Restructuring Activities (Continued)

Kindred at Home 2017 Efficiency Initiative

During the first quarter of 2017, the Kindred at Home division approved and initiated a cost and operations efficiency initiative to address increases in labor costs associated with competitive labor markets and the integration of pay practices from acquisitions across the Kindred at Home portfolio. This initiative included the consolidation and closure of under-performing branches and a reduction in force associated with the restructuring of divisional and regional support teams. These activities were substantially completed during 2017.

The composition of the restructuring costs that the Company has incurred for these consolidations is as follows (in thousands):

	Year ended December 31,		
	2017	2016	2015
Asset write-offs	\$ 4,616	\$ -	\$ -
Severance	2,423	-	-
Lease termination costs	1,524	-	-
Branch closure costs and gain on disposal	(245)	-	-
	<u>\$ 8,318</u>	<u>\$ -</u>	<u>\$ -</u>

The following table (in thousands) summarizes the related restructuring liability activity (included in current liabilities) during the year ended December 31, 2017, which does not include non-cash charges of \$4.6 million related to asset write-offs:

	Lease			
	termination costs			
Liability balance at December 31, 2016	\$ -	\$ -	-	\$ -
Expense	1,524	2,423	-	3,947
Payments	(564)	(2,420)	-	(2,984)
Other	-	39	-	39
Liability balance at December 31, 2017	<u>\$ 960</u>	<u>\$ 42</u>	<u>-</u>	<u>\$ 1,002</u>

Kindred at Home Branch Consolidations and Closures

During the first quarter of 2015, the Company approved and initiated branch consolidations and closures in specific markets to improve operations and cost efficiencies in the Kindred at Home division. The branch consolidations and closures included branches that served both the home health and hospice business segment operations. Gentiva initiated similar branch consolidations and closures prior to the Gentiva Merger and these activities and acquired liabilities are included herein. These activities were substantially completed during 2016.

The composition of the restructuring costs that the Company has incurred for these consolidations is as follows (in thousands):

	Year ended December 31,		
	2017	2016	2015
Lease termination costs	\$ 1,224	\$ 3,559	\$ 2,161
Asset write-offs	2,599	2,476	9,304
Branch closure and other costs	-	344	256
Severance	608	1,390	-
	<u>\$ 4,431</u>	<u>\$ 7,769</u>	<u>\$ 11,721</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 8 – RESTRUCTURING CHARGES (Continued)

Restructuring Activities (Continued)

Kindred at Home Branch Consolidations and Closures (Continued)

The following table (in thousands) summarizes the Company's Kindred at Home branch consolidation restructuring liability activity (included in current liabilities) for the two years ended December 31, 2017, which does not include non-cash charges of \$2.6 million and \$2.5 million related to asset write-offs in 2017 and 2016, respectively:

	Lease termination costs	Severance	Total
Liability balance at December 31, 2015	\$ 1,863	\$ -	\$ 1,863
Expense	3,559	1,390	4,949
Payments	(2,427)	(47)	(2,474)
Other	65	-	65
Liability balance at December 31, 2016	3,060	1,343	4,403
Expense	1,224	608	1,832
Payments	(3,295)	(2,175)	(5,470)
Other	(104)	224	120
Liability balance at December 31, 2017	<u>\$ 885</u>	<u>\$ -</u>	<u>\$ 885</u>

Division and Support Center Reorganizations

As a result of the Company's plan to exit the skilled nursing facility business, the Company plans to optimize its overhead structure by eliminating certain corporate and shared services overhead above the facility level. The activities related to the skilled nursing facility business exit are expected to be substantially complete in 2018.

During the year ended December 31, 2016, the Company initiated a restructuring plan to improve operations and cost efficiencies in the Kindred Rehabilitation Services division and support center. Actions related to these plans were completed during 2016.

The composition of the restructuring costs that the Company has incurred for these division reorganizations is as follows (in thousands):

	Year ended December 31,		
	2017	2016	2015
Severance, retention and other costs	<u>\$ 3,700</u>	<u>\$ 4,164</u>	<u>\$ -</u>

The following table summarizes the Company's skilled nursing facility business exit plan liability activity (included in current liabilities) (in thousands):

	Severance, retention and other costs
Liability balance at December 31, 2015	\$ -
Expense	4,164
Payments	(1,938)
Liability balance at December 31, 2016	2,226
Expense	3,700
Payments	(4,300)
Liability balance at December 31, 2017	<u>\$ 1,626</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 9 – LOSS PER SHARE

Loss per common share is based upon the weighted average number of common shares outstanding during the respective periods. Because the Company is reporting a loss from continuing operations attributable to the Company for the three years ended December 31, 2017, the diluted calculation of earnings per common share excludes the dilutive impact of stock options, performance-based restricted shares and tangible equity units of 1.4 million, 1.7 million and 2.6 million for 2017, 2016 and 2015, respectively. The Company follows the provisions of the authoritative guidance for determining whether instruments granted in share-based payment transactions are participating securities, which requires that unvested restricted stock that entitles the holder to receive nonforfeitable dividends before vesting be included as a participating security in the basic and diluted earnings per common share calculation pursuant to the two-class method. However, because the Company reported a loss from continuing operations attributable to the Company, there was no allocation to participating unvested restricted stockholders for all periods presented.

NOTE 10 – BUSINESS SEGMENT DATA

The Company is organized into three operating divisions: the Kindred at Home division, the hospital division, and the Kindred Rehabilitation Services division. Based upon the authoritative guidance for business segments, the Company's operating divisions represent five reportable operating segments, including (1) home health services, (2) hospice services, (3) hospitals, (4) Kindred Hospital Rehabilitation Services, and (5) RehabCare. These reportable operating segments are consistent with information used by the Company's President and Chief Executive Officer and its Chief Operating Officer to assess performance and allocate resources. The accounting policies of the operating segments are the same as those described in the summary of significant accounting policies.

The Company has reclassified certain retained businesses and expenses previously reported in the nursing center division, including hospital-based sub-acute units and a skilled nursing facility to the hospital division and a small therapy business to the Kindred Hospital Rehabilitation Services operating segment for all periods presented.

For segment purposes, the Company defines segment adjusted operating income as earnings before interest, income taxes, depreciation, amortization, and total rent reported for each of the Company's operating segments excluding litigation contingency expense, impairment charges, restructuring charges, transaction costs, and the allocation of support center overhead.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 10 – BUSINESS SEGMENT DATA (Continued)

The following tables set forth certain data by business segment (in thousands):

	Year ended December 31,		
	2017	2016	2015
Revenues:			
Kindred at Home:			
Home health	\$ 1,822,357	\$ 1,762,622	\$ 1,578,500
Hospice	743,443	736,803	656,527
	<u>2,565,800</u>	<u>2,499,425</u>	<u>2,235,027</u>
Hospital division	2,106,375	2,434,311	2,483,376
Kindred Rehabilitation Services:			
Kindred Hospital Rehabilitation Services	703,915	679,800	614,321
RehabCare	745,467	776,796	907,548
	<u>1,449,382</u>	<u>1,456,596</u>	<u>1,521,869</u>
	6,121,557	6,390,332	6,240,272
Eliminations:			
Kindred Hospital Rehabilitation Services	(77,398)	(89,724)	(91,301)
RehabCare	(7,533)	(5,803)	(29,477)
Hospitals	(2,503)	(2,276)	(276)
	<u>(87,434)</u>	<u>(97,803)</u>	<u>(121,054)</u>
	<u>\$ 6,034,123</u>	<u>\$ 6,292,529</u>	<u>\$ 6,119,218</u>
Loss from continuing operations:			
Segment adjusted operating income:			
Kindred at Home:			
Home health	\$ 276,218	\$ 279,531	\$ 256,173
Hospice	129,273	116,326	109,120
	<u>405,491</u>	<u>395,857</u>	<u>365,293</u>
Hospital division	337,487	441,644	486,213
Kindred Rehabilitation Services:			
Kindred Hospital Rehabilitation Services	203,392	198,335	177,340
RehabCare	6,884	32,586	35,876
	<u>210,276</u>	<u>230,921</u>	<u>213,216</u>
Support center expenses	(249,007)	(261,916)	(259,532)
Litigation contingency expense	(7,435)	(2,840)	(138,648)
Impairment charges	(381,179)	(314,729)	(24,757)
Restructuring charges	(40,343)	(34,734)	(10,250)
Transaction costs	-	(8,679)	(109,131)
Building rent	(257,516)	(264,306)	(257,221)
Equipment rent	(34,856)	(39,929)	(38,590)
Restructuring charges - rent	(44,518)	(61,392)	(2,368)
Depreciation and amortization	(104,805)	(131,819)	(129,246)
Interest, net	(237,912)	(231,504)	(229,595)
Loss from continuing operations before income taxes	(404,317)	(283,426)	(134,616)
Provision (benefit) for income taxes	(157,116)	314,262	(51,714)
	<u>\$ (247,201)</u>	<u>\$ (597,688)</u>	<u>\$ (82,902)</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 10 – BUSINESS SEGMENT DATA (Continued)

	Year ended December 31,		
	2017	2016	2015
Rent:			
Kindred at Home:			
Home health:			
Building	\$ 32,469	\$ 33,026	\$ 31,315
Equipment	1,028	1,302	1,607
	<u>33,497</u>	<u>34,328</u>	<u>32,922</u>
Hospice:			
Building	16,725	17,105	16,219
Equipment	331	334	420
	<u>17,056</u>	<u>17,439</u>	<u>16,639</u>
Hospital division:			
Building	172,040	177,381	175,795
Equipment	29,370	34,239	32,497
	<u>201,410</u>	<u>211,620</u>	<u>208,292</u>
Kindred Rehabilitation Services:			
Kindred Hospital Rehabilitation Services:			
Building	34,086	33,710	29,423
Equipment	1,685	1,567	1,357
	<u>35,771</u>	<u>35,277</u>	<u>30,780</u>
RehabCare:			
Building	1,281	1,276	1,236
Equipment	2,332	2,361	2,589
	<u>3,613</u>	<u>3,637</u>	<u>3,825</u>
Support center:			
Building	915	1,808	3,233
Equipment	110	126	120
	<u>1,025</u>	<u>1,934</u>	<u>3,353</u>
Totals:			
Building	257,516	264,306	257,221
Equipment	34,856	39,929	38,590
	<u>\$ 292,372</u>	<u>\$ 304,235</u>	<u>\$ 295,811</u>
Depreciation and amortization:			
Kindred at Home:			
Home health	\$ 10,759	\$ 15,721	\$ 17,279
Hospice	4,360	6,364	6,581
	<u>15,119</u>	<u>22,085</u>	<u>23,860</u>
Hospital division	41,827	50,618	54,049
Kindred Rehabilitation Services:			
Kindred Hospital Rehabilitation Services	14,881	14,538	13,523
RehabCare	4,161	7,961	7,780
	<u>19,042</u>	<u>22,499</u>	<u>21,303</u>
Support center	28,817	36,617	30,034
	<u>\$ 104,805</u>	<u>\$ 131,819</u>	<u>\$ 129,246</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 10 – BUSINESS SEGMENT DATA (Continued)

	Year ended December 31,		
	2017	2016	2015
Capital expenditures, excluding acquisitions (including discontinued operations):			
Kindred at Home:			
Home health:			
Routine	\$ 4,323	\$ 6,401	\$ 4,201
Development	-	-	-
	<u>4,323</u>	<u>6,401</u>	<u>4,201</u>
Hospice:			
Routine	2,379	2,342	1,215
Development	-	-	-
	<u>2,379</u>	<u>2,342</u>	<u>1,215</u>
Hospital division:			
Routine	18,304	23,858	28,935
Development	-	-	-
	<u>18,304</u>	<u>23,858</u>	<u>28,935</u>
Kindred Rehabilitation Services:			
Kindred Hospital Rehabilitation Services:			
Routine	2,743	1,389	948
Development	547	20,773	4,701
	<u>3,290</u>	<u>22,162</u>	<u>5,649</u>
RehabCare:			
Routine	1,820	1,867	1,449
Development	-	-	-
	<u>1,820</u>	<u>1,867</u>	<u>1,449</u>
Support center:			
Routine:			
Information systems	33,064	38,123	64,813
Other	1,525	4,695	1,589
Development	25,083	8,117	3,484
	<u>59,672</u>	<u>50,935</u>	<u>69,886</u>
Discontinued operations - nursing centers:			
Routine	5,648	17,377	18,781
Development	265	5,935	11,746
	<u>5,913</u>	<u>23,312</u>	<u>30,527</u>
Totals:			
Routine	69,806	96,052	121,931
Development	25,895	34,825	19,931
	<u>\$ 95,701</u>	<u>\$ 130,877</u>	<u>\$ 141,862</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 10 – BUSINESS SEGMENT DATA (Continued)

	December 31, 2017	December 31, 2016
Assets at end of period:		
Kindred at Home:		
Home health	\$ 1,540,010	\$ 1,540,370
Hospice	913,230	929,774
	<u>2,453,240</u>	<u>2,470,144</u>
Hospital division	990,011	1,232,541
Kindred Rehabilitation Services:		
Kindred Hospital Rehabilitation Services	828,310	815,804
RehabCare	189,469	329,516
	<u>1,017,779</u>	<u>1,145,320</u>
Support center	522,677	795,415
Discontinued operations - nursing centers	249,010	469,304
	<u>\$ 5,232,717</u>	<u>\$ 6,112,724</u>
Goodwill:		
Kindred at Home:		
Home health	\$ 917,239	\$ 919,482
Hospice	646,329	646,329
	<u>1,563,568</u>	<u>1,565,811</u>
Hospital division	125,045	361,310
Kindred Rehabilitation Services:		
Kindred Hospital Rehabilitation Services	499,953	499,953
RehabCare	-	-
	<u>499,953</u>	<u>499,953</u>
	<u>\$ 2,188,566</u>	<u>\$ 2,427,074</u>

NOTE 11 – INCOME TAXES

The Tax Reform Act, which was enacted on December 22, 2017, is generally effective in 2018 and makes broad and significantly complex changes to the federal corporate tax system, including the reduction in the U.S. federal corporate income tax rate from 35% to 21% and the limitation on the deductibility of interest expense. The Company estimated the impact of the Tax Reform Act to deferred income taxes on its December 31, 2017 balance sheet in accordance with its understanding of the Tax Reform Act and guidance available as of the date of this filing. As a result, the Company has recorded an estimated \$130.5 million income tax benefit related to reducing certain deferred income tax liabilities in the fourth quarter of 2017.

In December 2017, the FASB issued authoritative guidance to address the application of GAAP in situations when a registrant does not have the necessary information available, prepared, or analyzed (including computations) in reasonable detail to complete the accounting for certain income tax effects of the Tax Reform Act. In accordance with this authoritative guidance, the Company has determined that the \$130.5 million income tax benefit recorded in connection with the assessment of the valuation allowance is a provisional amount and a reasonable estimate that may change. Additional work is necessary to complete a more detailed analysis of the Tax Reform Act.

The estimated impact of \$130.5 million from the Tax Reform Act resulted from both the reassessment of the deferred income tax valuation allowance and the change in the income tax rate. The removal of the carryforward period for federal net operating losses (“NOLs”) under the Tax Reform Act resulted in a portion of the remaining deferred tax liability becoming available as a source-of-income that can be used to offset certain deferred tax assets. This change resulted in the Company releasing \$118.4 million of its deferred income tax valuation allowance. The change in the income tax rate from 35% to 21% resulted in the Company’s deferred liability being reduced by \$12.1 million.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 11 – INCOME TAXES (Continued)

At each balance sheet date, management assesses all available positive and negative evidence to determine whether a valuation allowance is needed against its deferred tax assets. The authoritative guidance requires evidence related to events that have actually happened to be weighted more significantly than evidence that is projected or expected to happen. A significant piece of negative evidence according to this weighting standard is if there are cumulative losses in the two most recent years and the current year, which was the case for the Company at December 31, 2017 and December 31, 2016. The Company's outlook of taxable income for 2016 changed after the Company recorded \$286.8 million of goodwill and property and equipment impairment charges and announced the planned SNF Divestiture and related expected loss on divestiture for tax purposes. Accordingly, a full valuation allowance was recorded at both December 31, 2017 and December 31, 2016. The amount of deferred tax asset considered realizable, however, could be adjusted if the weighting of the positive and negative evidence changes.

The Company's valuation allowance was reduced to \$378.8 million at December 31, 2017 from \$423.1 million at December 31, 2016. The Company recorded an increase to the valuation allowance of \$ 246.4 million before the impact of the Tax Reform Act, which required a reduction in the valuation allowance of \$290.7 million, comprised of both the \$130.5 million decrease in deferred tax liabilities discussed above and a \$160.2 million decrease to deferred tax assets and related valuation allowance based upon the change in the U.S. corporate income tax rate from 35% to 21%.

The Company has deferred tax liabilities related to tax amortization of acquired indefinite-lived intangible assets because these assets are not amortized for financial reporting purposes. The tax amortization in current and future years created a deferred tax liability which will reverse at the time of ultimate sale or book impairment. Prior to the Tax Reform Act, the uncertain timing of this reversal and the temporary difference associated with certain indefinite lived intangible assets could not be considered a source of future taxable income for purposes of determining the valuation allowance. As such, certain deferred tax liabilities could not be used to offset deferred tax assets. As a result of the Tax Reform Act, a portion of the Company's federal indefinite-lived intangible assets can be used as a source of income. As a result of this change and other activity in 2017, the Company's net deferred tax liability was reduced to \$36.9 million at December 31, 2017 from \$201.8 million at December 31, 2016. The deferred tax liability at December 31, 2017 is comprised of the entire state portion of indefinite-lived intangible assets and a portion of the Company's federal indefinite-lived intangible assets that could not be used as a source of income. The deferred tax liability at December 31, 2016 is comprised entirely of both federal and state indefinite-lived intangible assets that could not be used as a source of income. This change in deferred tax liabilities available as a source of income relates to changes in carryforward periods and limitations that no longer exist. The new 80% limitation on NOLs creates a new limitation for federal purposes that must be considered.

Provision (benefit) for income taxes consists of the following (in thousands):

	Year ended December 31,		
	2017	2016	2015
Current:			
Federal	\$ -	\$ -	\$ -
State	3,992	3,992	3,683
	3,992	3,992	3,683
Deferred	(161,108)	310,270	(55,397)
	<u>\$ (157,116)</u>	<u>\$ 314,262</u>	<u>\$ (51,714)</u>

Reconciliation of federal statutory tax benefit to the provision (benefit) for income taxes follows (in thousands):

	Year ended December 31,		
	2017	2016	2015
Income tax benefit at federal rate	\$ (141,511)	\$ (99,199)	\$ (47,116)
State income tax benefit, net of federal income tax benefit	(17,588)	(12,424)	(4,951)
Transaction costs	3,380	-	4,832
Impairment charges	54,644	66,357	890
Valuation allowance (prior to the Tax Reform Act)	88,398	368,664	-
Prior year contingencies	232	-	426
Noncontrolling interests	(17,391)	(14,384)	(10,424)
Compensation related charges	1,381	1,204	3,055
Federal and state tax credits	(1,541)	(1,698)	(3,033)
Impact of the Tax Reform Act	(130,453)	-	-
Other items, net	3,333	5,742	4,607
	<u>\$ (157,116)</u>	<u>\$ 314,262</u>	<u>\$ (51,714)</u>

Other items consist of meals, entertainment, lobbying, and other permanent differences, which individually are deemed immaterial.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 11 – INCOME TAXES (Continued)

A summary of net deferred income tax assets (liabilities) by source included in the accompanying consolidated balance sheet at December 31 follows (in thousands):

	2017		2016	
	Assets	Liabilities	Assets	Liabilities
Property and equipment	\$ -	\$ 11,572	\$ -	\$ 18,457
Insurance	80,800	-	50,901	-
Account receivable allowances	31,809	-	39,739	-
Compensation	34,252	-	56,746	-
Net operating losses	244,424	-	222,828	-
Assets held for sale	-	1,847	-	-
Litigation	-	-	-	-
Goodwill and intangibles	-	98,048	-	226,490
Lease amendments	14,991	-	17,426	-
Jobs tax and other credits	22,795	-	28,310	-
Other	24,347	-	50,343	-
	453,418	\$ 111,467	466,293	\$ 244,947
Reclassification of deferred tax liabilities	(111,467)		(244,947)	
Net deferred tax assets	341,951		221,346	
Valuation allowance	(378,832)		(423,154)	
	\$ (36,881)		\$ (201,808)	

Net deferred income tax liabilities totaling \$36.9 million and \$201.8 million at December 31, 2017 and 2016, respectively, were classified as noncurrent liabilities.

The Company identified deferred tax assets for federal income tax NOLs of \$162.2 million (tax effected at 21%) and \$162.4 million (tax effected at 35%) at December 31, 2017 and December 31, 2016, respectively, with corresponding deferred income tax valuation allowances of \$162.2 million and \$162.4 million at December 31, 2017 and December 31, 2016, respectively. The federal income tax NOLs expire in various amounts through 2037. The Company had deferred income tax assets for state income tax NOLs of \$82.2 million and \$60.4 million at December 31, 2017 and December 31, 2016, respectively, and corresponding deferred income tax valuation allowances of \$82.0 million and \$60.0 million at December 31, 2017 and December 31, 2016, respectively, for that portion of the net deferred income tax assets that the Company will likely not realize in the future.

The Company follows the provisions of the authoritative guidance for accounting for uncertainty in income taxes which clarifies the accounting for uncertain income tax issues recognized in an entity's financial statements. The guidance prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in an income tax return.

A reconciliation of unrecognized tax benefits follows (in thousands):

Balance, December 31, 2014	\$ -
Acquisition	6,814
Balance, December 31, 2015	6,814
Reductions due to the conclusion of income tax examinations	(1,001)
Balance, December 31, 2016	5,813
Reductions due to the conclusion of income tax examinations	-
Balance, December 31, 2017	\$ 5,813

The Company records accrued interest and penalties associated with uncertain tax positions as income tax expense in the consolidated statement of operations. Accrued interest related to uncertain tax provisions totaled \$3.5 million as of December 31, 2017 and \$3.3 million as of December 31, 2016.

The federal statute of limitations remains open for tax years 2014 through 2016. During 2017, the Company resolved federal income tax audits for the 2015 tax year. During 2017, Gentiva and its subsidiaries also resolved federal tax audits for the February 1, 2015 short-period tax return. The Company is currently under examination by the Internal Revenue Service (the "IRS") for the 2016 and 2017 tax years. The Company has been accepted into the IRS Compliance Assurance Process ("CAP") program for the 2016 through 2018 tax years. The CAP program is an enhanced, real-time review of a company's tax positions and compliance. The Company expects participation in the CAP program will improve the timeliness of its federal tax examinations.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 11 – INCOME TAXES (Continued)

State jurisdictions generally have statutes of limitations for tax returns ranging from three to five years. The state impact of federal income tax changes remains subject to examination by various states for a period of up to one year after formal notification to the states. Currently, the Company has various state income tax returns under examination.

NOTE 12 – INSURANCE RISKS

In October 2017, in connection with the review of the Company’s insurance programs as part of the SNF Divestiture, the Company restructured the funding and retention mechanisms of recent policy years of its professional liability and workers compensation insurance programs (the “Insurance Restructuring”). With respect to professional liability, certain funding mechanisms and reinsurance agreements were modified such that approximately \$106 million of cash deposits maintained by Cornerstone and \$4 million of other cash deposits were released to the parent company. In addition, approximately \$115 million of workers compensation restricted cash collateral deposits were replaced with letters of credit (see Note 15) and approximately \$21 million of other workers compensation cash deposits were released to the parent company. In aggregate, the Company used the approximately \$246 million generated from the Insurance Restructuring and \$35 million of the distributions received from Cornerstone as a result of improved underwriting results during the last two quarters of 2017 to repay in its entirety the Company’s ABL Facility (as defined in Note 15) balance and to increase cash reserves. The Company incurred \$10.4 million of contract cancellation costs and professional fees during 2017 in connection with the Insurance Restructuring.

As a result of the Insurance Restructuring, on a per-claim basis the Company maintains a self-insured retention and Cornerstone insures all losses in excess of this retention. Cornerstone maintains commercial reinsurance through unaffiliated commercial reinsurers for these losses in excess of our retention. The Insurance Restructuring had no impact upon the financial risk transfer aspect of Cornerstone’s reinsurance agreements with its third party reinsurers. As a result of the Insurance Restructuring, on a per-claim basis the Company maintains a deductible under commercial insurance policies for workers compensation which provide coverage up to statutory limits in each state. The Insurance Restructuring had no impact upon the financial risk transfer aspect of these third party insurance agreements. The provisions for loss for these professional liability and workers compensation risks are based upon management’s best available information, including actuarially determined estimates of loss.

The allowance for professional liability risks includes an estimate of the expected cost to settle reported claims and an amount, based upon past experiences, for losses incurred but not reported. These liabilities are necessarily based upon estimates and, while management believes that the provision for loss is adequate, the ultimate liability may be in excess of, or less than, the amounts recorded. To the extent that expected ultimate claims costs vary from historical provisions for loss, future earnings will be charged or credited.

The provision for loss for insurance risks, including the cost of coverage maintained with unaffiliated commercial reinsurance and insurance carriers, follows (in thousands):

	Year ended December 31,		
	2017	2016	2015
Professional liability:			
Continuing operations	\$ 41,715	\$ 53,451	\$ 49,452
Discontinued operations	22,836	23,903	17,190
Workers compensation:			
Continuing operations	\$ 33,626	\$ 48,331	\$ 44,796
Discontinued operations	3,603	5,487	2,700

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 12 – INSURANCE RISKS (Continued)

Changes in the allowance for professional liability risks and workers compensation risks for the years ended December 31 follow (including discontinued operations) (in thousands):

	2017			2016		
	Professional liability	Workers compensation	Total	Professional liability	Workers compensation	Total
Allowance for insurance risks at beginning of year	\$ 360,595	\$ 265,208	\$ 625,803	\$ 327,372	\$ 254,849	\$ 582,221
Provision for loss for retained insurance risks:						
Current year	64,649	49,143	113,792	66,750	52,754	119,504
Prior years	<u>(12,764)</u>	<u>(28,445)</u>	<u>(41,209)</u>	<u>(2,310)</u>	<u>(14,018)</u>	<u>(16,328)</u>
	51,885	20,698	72,583	64,440	38,736	103,176
Provision for reinsurance and insurance, administrative and overhead costs	12,666	16,531	29,197	12,914	15,082	27,996
Discount accretion	1,110	-	1,110	953	-	953
Contributions from managed facilities	508	349	857	273	496	769
Payments for insurance risks:						
Current year	(3,937)	(10,584)	(14,521)	(3,884)	(12,026)	(15,910)
Prior years	<u>(97,478)</u>	<u>(28,642)</u>	<u>(126,120)</u>	<u>(66,639)</u>	<u>(32,606)</u>	<u>(99,245)</u>
	(101,415)	(39,226)	(140,641)	(70,523)	(44,632)	(115,155)
Payments for reinsurance and insurance, administrative and overhead costs	(12,666)	(16,531)	(29,197)	(12,914)	(15,082)	(27,996)
Change in reinsurance and other recoverables	24,913	(3,633)	21,280	38,080	15,759	53,839
Allowance for insurance risks at end of year	<u>\$ 337,596</u>	<u>\$ 243,396</u>	<u>\$ 580,992</u>	<u>\$ 360,595</u>	<u>\$ 265,208</u>	<u>\$ 625,803</u>

	2015		
	Professional liability	Workers compensation	Total
Allowance for insurance risks at beginning of year	\$ 307,751	\$ 189,259	\$ 497,010
Provision for loss for retained insurance risks:			
Current year	55,498	55,172	110,670
Prior years	<u>(1,173)</u>	<u>(18,151)</u>	<u>(19,324)</u>
	54,325	37,021	91,346
Provision for reinsurance and insurance, administrative and overhead costs	12,317	10,475	22,792
Discount accretion	1,190	-	1,190
Contributions from managed facilities	220	344	564
Acquisitions	13,948	64,223	78,171
Payments for insurance risks:			
Current year	(6,158)	(11,483)	(17,641)
Prior years	<u>(68,611)</u>	<u>(36,842)</u>	<u>(105,453)</u>
	(74,769)	(48,325)	(123,094)
Payments for reinsurance and insurance, administrative and overhead costs	(12,317)	(10,475)	(22,792)
Change in reinsurance and other recoverables	24,707	12,327	37,034
Allowance for insurance risks at end of year	<u>\$ 327,372</u>	<u>\$ 254,849</u>	<u>\$ 582,221</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 12 – INSURANCE RISKS (Continued)

A summary of the assets and liabilities related to insurance risks included in the accompanying consolidated balance sheet at December 31 follows (in thousands):

	2017			2016		
	Professional liability	Workers compensation	Total	Professional liability	Workers compensation	Total
Assets:						
Current:						
Insurance subsidiary investments	\$ 17,577	\$ 4,969	\$ 22,546	\$ 64,622	\$ 44,344	\$ 108,966
Reinsurance and other recoverables	3,331	969	4,300	7,912	1,488	9,400
Other	-	50	50	-	50	50
	20,908	5,988	26,896	72,534	45,882	118,416
Non-current:						
Insurance subsidiary investments	9,576	19,412	28,988	97,223	107,706	204,929
Reinsurance and other recoverables	103,058	97,624	200,682	111,596	101,984	213,580
Deposits	27	1,949	1,976	4,202	22,979	27,181
	112,661	118,985	231,646	213,021	232,669	445,690
	\$ 133,569	\$ 124,973	\$ 258,542	\$ 285,555	\$ 278,551	\$ 564,106
Liabilities:						
Allowance for insurance risks:						
Current	\$ 60,767	\$ 42,394	\$ 103,161	\$ 65,284	\$ 48,237	\$ 113,521
Non-current	276,829	201,002	477,831	295,311	216,971	512,282
	\$ 337,596	\$ 243,396	\$ 580,992	\$ 360,595	\$ 265,208	\$ 625,803

In connection with the Insurance Restructuring, the provision for loss for professional liability risks is no longer discounted and no longer funded to Cornerstone. Prior to the Insurance Restructuring, provisions for loss for professional liability risks retained by Cornerstone were discounted based upon actuarial estimates of claim payment patterns using a discount rate of 1%. The discount rate was based upon the risk-free interest rate for the respective year. Amounts equal to the discounted loss provision were funded annually. The Company does not fund the portion of professional liability risks related to estimated claims that have been incurred but not reported. Accordingly, these liabilities were not discounted. If the Company had not discounted any of the allowances for professional liability risks, these balances would have approximated \$363.2 million at December 31, 2016.

In connection with the Insurance Restructuring, the provision for loss for workers compensation risks is no longer funded to Cornerstone.

NOTE 13 – INSURANCE SUBSIDIARY INVESTMENTS

In connection with the Insurance Restructuring, the Company liquidated a significant portion of its insurance subsidiary investments and released that cash back to the parent to repay debt and increase cash reserves. The Company maintains a portfolio of insurance subsidiary investments, consisting of cash and cash equivalents at December 31, 2017, for the payment of claims and expenses related to professional liability and workers compensation risks maintained by its limited purpose insurance subsidiary. These investments have been categorized as available-for-sale and are reported at fair value.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 13 – INSURANCE SUBSIDIARY INVESTMENTS (Continued)

The cost for equities, amortized cost for debt securities and estimated fair value of the Company's insurance subsidiary investments at December 31 follows (in thousands):

	2017				2016			
	Cost	Unrealized gains	Unrealized losses	Fair value	Cost	Unrealized gains	Unrealized losses	Fair value
Cash and cash equivalents (a)	\$ 51,534	\$ -	\$ -	\$ 51,534	\$ 185,152	\$ -	\$ -	\$ 185,152
Debt securities:								
Corporate bonds	-	-	-	-	55,239	37	(100)	55,176
U.S. Treasury notes	-	-	-	-	24,763	6	(42)	24,727
Debt securities issued by U.S. government agencies	-	-	-	-	18,344	7	(63)	18,288
	-	-	-	-	98,346	50	(205)	98,191
Equities by industry:								
Consumer	-	-	-	-	2,596	66	(150)	2,512
Technology	-	-	-	-	2,105	120	(23)	2,202
Financial services	-	-	-	-	1,641	213	(24)	1,830
Industrials	-	-	-	-	1,291	57	(19)	1,329
Healthcare	-	-	-	-	1,332	-	(86)	1,246
Other	-	-	-	-	6,530	109	(70)	6,569
	-	-	-	-	15,495	565	(372)	15,688
Certificates of deposit	-	-	-	-	14,850	14	-	14,864
	<u>\$ 51,534</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 51,534</u>	<u>\$ 313,843</u>	<u>\$ 629</u>	<u>\$ (577)</u>	<u>\$ 313,895</u>

(a) Includes \$4.9 million and \$14.8 million of money market funds at December 31, 2017 and 2016, respectively.

At December 31, 2017, all of the available-for-sale investments of the Company's insurance subsidiary have maturity dates within one year.

Since the Company's insurance subsidiary investments are restricted for a limited purpose, they are classified in the accompanying consolidated balance sheet based upon the expected current and long-term cash requirements of the limited purpose insurance subsidiary.

Net investment income earned by the Company's insurance subsidiary investments follows (in thousands):

	Year ended December 31,		
	2017	2016	2015
Interest income	\$ 1,973	\$ 1,850	\$ 1,461
Net amortization of premium and accretion of discount	(187)	(252)	(348)
Gains on sale of investments	2,039	1,539	646
Losses on sale of investments	(588)	(173)	(33)
Other-than-temporary impairments	-	(160)	(440)
Investment expenses	(177)	(221)	(215)
	<u>\$ 3,060</u>	<u>\$ 2,583</u>	<u>\$ 1,071</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 13 – INSURANCE SUBSIDIARY INVESTMENTS (Continued)

The available-for-sale investments of the Company’s insurance subsidiary which have unrealized losses at December 31, 2016 are shown below. The investments are categorized by the length of time that individual securities have been in a continuous unrealized loss position at December 31, 2016.

December 31, 2016 (In thousands)	Less than one year		One year or greater		Total	
	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses
Debt securities:						
Corporate bonds	\$ 27,406	\$ 100	\$ -	\$ -	\$ 27,406	\$ 100
U.S. Treasury notes	11,120	42	-	-	11,120	42
Debt securities issued by U.S. government agencies	10,712	63	-	-	10,712	63
	49,238	205	-	-	49,238	205
Equities by industry:						
Consumer	1,294	150	-	-	1,294	150
Technology	459	23	-	-	459	23
Financial services	-	-	152	24	152	24
Industrials	-	-	422	19	422	19
Healthcare	1,246	86	-	-	1,246	86
Other	2,267	70	-	-	2,267	70
	5,266	329	574	43	5,840	372
	\$ 54,504	\$ 534	\$ 574	\$ 43	\$ 55,078	\$ 577

The unrealized losses on equities totaling \$0.4 million at December 31, 2016 were due generally to market fluctuations. Accordingly, the Company believes these unrealized losses are temporary in nature.

The Company’s investment policy governing insurance subsidiary investments precludes the investment portfolio managers from selling any security at a loss without prior authorization from the Company. The investment managers also limit the exposure to any one issue, issuer or type of investment. The Company intends, and has the ability, to hold insurance subsidiary investments for a long duration without the necessity of selling securities to fund the underwriting needs of its insurance subsidiary. This ability to hold securities allows sufficient time for recovery of temporary declines in the market value of equity securities and the par value of debt securities as of their stated maturity date.

The Company considered the severity and duration of its unrealized losses at December 31, 2016 and recognized pretax other-than-temporary impairments of \$0.2 million for various investments held in its insurance subsidiary investment portfolio. These investments were determined to be impaired after considering the duration of the declines in value and the likelihood of near term price recovery of each investment. Because the Company considered the remaining unrealized losses at December 31, 2016 to be temporary, the Company did not record any additional impairment losses related to these investments.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 14 – LEASES

The Company leases real estate and equipment under cancelable and non-cancelable arrangements. The following table sets forth rent expense by business segment (in thousands):

	Year ended December 31,		
	2017	2016	2015
Kindred at Home:			
Home health:			
Buildings	\$ 32,469	\$ 33,026	\$ 31,315
Equipment	1,028	1,302	1,607
	<u>33,497</u>	<u>34,328</u>	<u>32,922</u>
Hospice:			
Buildings	16,725	17,105	16,219
Equipment	331	334	420
	<u>17,056</u>	<u>17,439</u>	<u>16,639</u>
Hospital division:			
Buildings:			
Ventas	114,161	118,053	118,511
Other landlords	57,879	59,328	57,284
Equipment	29,370	34,239	32,497
	<u>201,410</u>	<u>211,620</u>	<u>208,292</u>
Kindred Rehabilitation Services:			
Kindred Hospital Rehabilitation Services:			
Buildings	34,086	33,710	29,423
Equipment	1,685	1,567	1,357
	<u>35,771</u>	<u>35,277</u>	<u>30,780</u>
RehabCare:			
Buildings	1,281	1,276	1,236
Equipment	2,332	2,361	2,589
	<u>3,613</u>	<u>3,637</u>	<u>3,825</u>
Support center:			
Buildings	915	1,808	3,233
Equipment	110	126	120
	<u>1,025</u>	<u>1,934</u>	<u>3,353</u>
Totals:			
Buildings:			
Ventas	114,161	118,053	118,511
Other landlords	143,355	146,253	138,710
Equipment	34,856	39,929	38,590
	<u>\$ 292,372</u>	<u>\$ 304,235</u>	<u>\$ 295,811</u>

Various facility leases include contingent annual rent escalators based upon a change in the Consumer Price Index or other agreed upon terms such as a patient revenue test. These contingent rents are included in rent expense in the year incurred. The Company recorded contingent rent of \$1.9 million, \$0.8 million and \$0.5 million for the years ended December 31, 2017, 2016 and 2015, respectively, including both continuing operations and discontinued operations.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 14 – LEASES (Continued)

Future minimum payments under non-cancelable operating leases are as follows (in thousands):

	Minimum payments		
	Ventas	Other	Total
2018	\$ 110,319	\$ 128,494	\$ 238,813
2019	111,201	112,606	223,807
2020	112,231	96,762	208,993
2021	113,225	84,968	198,193
2022	114,179	69,687	183,866
Thereafter	219,505	306,920	526,425

Ventas master lease agreement

At December 31, 2017, the Company leased from Ventas and its affiliates 29 TC hospitals under one master lease agreement (the “Master Lease Agreement”). The Master Lease Agreement includes land, buildings, structures, and other improvements on the land, easements, and similar appurtenances to the land and improvements, and permanently affixed equipment, machinery, and other fixtures relating to the operation of the leased properties. There are one or more bundles of leased properties under the Master Lease Agreement, with each bundle containing several TC hospitals.

As part of the SNF Divestiture, the Company entered into an agreement with Ventas in 2016 which provided the Company with the option to acquire the real estate for all 36 skilled nursing facilities (previously defined as the “Ventas Properties”) that were leased from Ventas for an aggregate consideration of \$700 million. As of December 31, 2017, the Company had acquired all of the Ventas Properties from Ventas, and all but two of such Ventas Properties were sold to third parties in the SNF Divestiture.

Recent master lease amendments

On November 7, 2017, the Company and Ventas amended the Master Lease Agreement in connection with its purchase and closure of one of the TC hospitals leased thereunder. As part of such amendment, the Company paid Ventas \$3 million for the real estate of such TC hospital, with the annual rent otherwise payable for such TC hospital of \$5.0 million reallocated among the remaining facilities leased under the Master Lease Agreement. For accounting purposes, the reallocated rent is treated as a one-time non-cash lease termination charge. The Company recorded a \$32.3 million lease termination charge in the fourth quarter of 2017 in connection with this transaction. The lease termination fee was recorded as a long-term liability discounted at the Company’s credit-adjusted risk-free rate through the end of 2025, which is the original lease term of the TC hospital. This lease termination fee was recorded as a restructuring charge in the accompanying consolidated statement of operations.

Concurrently with the execution and delivery of the Merger Agreement, on December 19, 2017, the Company and Ventas entered into an Amendment No. 2 (the “Ventas Lease Amendment”) to the Master Lease Agreement pursuant to which, among other things, (i) Ventas agreed that the transactions contemplated by the Merger Agreement and the Separation Agreement comply with the Master Lease Agreement, subject to the satisfaction of the remaining requirements in the Master Lease Agreement related thereto, including payment to Ventas of a transaction fee equal to 10% of annual base rent under the Master Lease Agreement upon closing of the transactions, (ii) the Company agreed to pay to Ventas an additional \$5 million fee within one business day of the signing of the Merger Agreement in exchange for Ventas’ approval of and agreement not to challenge the transaction structure (this condition was satisfied on December 20, 2017), (iii) the Company agreed to complete the purchase of the two remaining skilled nursing facilities under the Master Lease Agreement and our former Second Amended and Restated Master Lease No. 2 from Ventas, and pay corresponding expense reimbursements to Ventas, on or before December 31, 2017 (this condition was satisfied on December 21, 2017), and (iv) the Company agreed to make certain minimum expenditures for the leased facilities remaining under the Master Lease Agreement going forward.

In connection with the Curahealth Disposal, the Company entered into amendments to certain of its master lease agreements on April 3, 2016 to transition the operations for seven TC hospitals (the “Leased Hospitals”). The Leased Hospitals were leased under the applicable master lease agreement until the closing of the Curahealth Disposal on October 1, 2016. The Company paid a fee to Ventas of \$3.5 million upon signing of the amendments and paid an additional \$3 million upon the closing of the sale of the Leased Hospitals. Ventas paid the Company 50% of the sales proceeds for the real estate (after deduction of its closing costs) attributed to the Leased Hospitals in the sale, which was immaterial. Under separate lease amendments, the annual rent on the Leased Hospitals, which had annual rent of \$7.7 million, was reallocated to the remaining facilities the Company leases from Ventas under the various master lease agreements. As required under GAAP, the reallocated rents were recorded as a lease termination fee by the Company upon the cease use date of the Leased Hospitals.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 14 – LEASES (Continued)

Recent master lease amendments (Continued)

In connection with these transactions, the Company incurred a pretax lease termination fee of \$52.3 million comprised of the \$6.5 million of fees paid to Ventas in conjunction with execution of the amendments and \$45.8 million of aggregate reallocated rents attributable to the Leased Hospitals, which was recorded upon the cease use date of the Leased Hospitals. The lease termination fee was recorded as a long-term liability discounted at the Company's credit-adjusted risk-free rate through the end of the original lease term of the Leased Hospitals, or through 2025. These lease termination fees were recorded as restructuring charges in the accompanying consolidated statement of operations.

Rental amounts and escalators

The Master Lease Agreement is commonly known as a triple-net lease or an absolute-net lease. Accordingly, in addition to rent, the Company is required to pay the following: (1) all insurance required in connection with the leased properties and the business conducted on the leased properties, (2) certain taxes levied on or with respect to the leased properties (other than taxes on the income of Ventas), and (3) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties.

The Company paid rents to Ventas (including amounts classified within discontinued operations) approximating \$154.4 million for the year ended December 31, 2017, \$167.7 million for the year ended December 31, 2016, and \$171.8 million for the year ended December 31, 2015.

The Master Lease Agreement provides for rent escalations each May 1. All annual rent escalators are payable in cash. The contingent annual rent escalator for the Master Lease Agreement is based upon annual increases in the Consumer Price Index, subject to a ceiling of 4%. In 2017, the contingent annual rent escalator was 2.74% for the Master Lease Agreement.

NOTE 15 – LONG-TERM DEBT

Capitalization

A summary of long-term debt at December 31 follows (in thousands):

	2017	2016
Term Loan Facility due 2021, net of unamortized original issue discount of \$5.1 million at December 31, 2017 and \$6.7 million at December 31, 2016	\$ 1,350,312	\$ 1,362,772
8.00% Notes due 2020	750,000	750,000
8.75% Notes due 2023	600,000	600,000
6.375% Notes due 2022	500,000	500,000
ABL Facility	-	62,500
Mandatory Redeemable Preferred Stock (see Note 16)	-	12,372
Capital lease obligations	312	580
Other	669	1,446
Debt issuance costs, net of accumulated amortization	(39,683)	(46,631)
Total debt, average life of 4 years (weighted average rate 6.7% for 2017 and 6.5% for 2016)	3,161,610	3,243,039
Amounts due within one year	(14,638)	(27,977)
Long-term debt	<u>\$ 3,146,972</u>	<u>\$ 3,215,062</u>

The following table summarizes scheduled maturities of long-term debt (in thousands):

	Term Loan Facility due 2021	8.00% Notes due 2020	8.75% Notes due 2023	6.375% Notes due 2022	Capital lease obligations	Other	Total
2018	\$ 14,034	\$ -	\$ -	\$ -	\$ 210	\$ 394	\$ 14,638
2019	14,034	-	-	-	102	257	14,393
2020	14,034	750,000	-	-	-	18	764,052
2021	1,313,326	-	-	-	-	-	1,313,326
2022	-	-	-	500,000	-	-	500,000
Thereafter	-	-	600,000	-	-	-	600,000
	<u>\$ 1,355,428</u>	<u>\$ 750,000</u>	<u>\$ 600,000</u>	<u>\$ 500,000</u>	<u>\$ 312</u>	<u>\$ 669</u>	<u>\$ 3,206,409</u>

The estimated fair value of the Company's long-term debt approximated \$3.3 billion and \$3.2 billion at December 31, 2017 and December 31, 2016, respectively. See Note 21.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 15 – LONG-TERM DEBT (Continued)

Credit Facilities

As used herein, the “Credit Facilities” refers collectively to the Term Loan Facility and the ABL Facility, in each case as defined and described below.

Term Loan Facility

The “Term Loan Facility” refers to the Company’s \$1.36 billion term loan credit facility provided pursuant to the terms and provisions of that certain Sixth Amended and Restated Term Loan Credit Agreement dated as of March 14, 2017 (the “Term Loan Credit Agreement”), among the Company, the lenders from time to time party thereto, and JPMorgan Chase Bank, N.A., as administrative agent and collateral agent. All obligations under the Term Loan Facility are fully and unconditionally guaranteed, subject to certain customary release provisions, by substantially all of the Company’s wholly owned, domestic material subsidiaries, as well as certain non-wholly owned domestic subsidiaries as the Company may determine from time to time in its sole discretion.

The Term Loan Facility (1) matures on April 9, 2021, (2) contains financial maintenance covenants in the form of a maximum total leverage ratio, a minimum fixed charge coverage ratio and a maximum amount of annual capital expenditures, (3) imposes restrictions on the Company’s ability to incur debt and liens and make acquisitions, investments and payments on equity and junior debt, and (4) provides for interest rate margins of 3.50% for the London Interbank Offered Rate (“LIBOR”) borrowings (subject to a floor of 1.00%) and 2.50% for base rate borrowings.

A summary of the amendments to the Term Loan Facility since January 1, 2015 is set forth below.

On March 14, 2017, the Company entered into the Term Loan Credit Agreement that amended and restated the Term Loan Facility to, among other things, (1) make adjustments to certain covenants and definitions to better accommodate the SNF Divestiture, (2) provide the Company with increased leverage covenant flexibility for an interim period, (3) increase the applicable margin on the outstanding borrowings from 3.25% to 3.50% for LIBOR borrowings and from 2.25% to 2.50% for base rate borrowings, (4) require a maximum leverage ratio of no more than 5.00 to 1.00 for use of the \$50 million annual dividend basket, and (5) provide for a prepayment premium of 1.00% in connection with any repricing transaction within six months of the closing date. In accordance with the authoritative guidance on debt, the Company accounted for the amendment as a debt modification.

On June 14, 2016, the Company amended and restated the Term Loan Facility to provide for, among other things, (1) additional joint venture flexibility, including an increased ability to enter into and make investments in joint ventures that are non-guarantor restricted subsidiaries and to incur debt and liens of such joint ventures and other non-guarantor restricted subsidiaries, (2) an increase in the size of a basket for asset sales from 15% to 25% of consolidated total assets, (3) maintaining a maximum total leverage ratio of 6.00:1.00 for each quarterly measurement date after the date of such amendment, and (4) an incremental term loan in an aggregate principal amount of \$200 million. The incremental term loan was issued with 95 basis points of original issue discount (“OID”) and has the same terms as, and is fungible with, the \$1.18 billion in aggregate principal amount of term loans that were then outstanding under the Term Loan Facility. The net proceeds from the incremental term loan were used to repay a portion of the outstanding borrowings under the ABL Facility.

On March 10, 2015, the Company entered into an incremental amendment agreement to the Term Loan Facility that provided for an incremental term loan in an aggregate principal amount of \$200 million under the Term Loan Facility. The Company used the net proceeds of the incremental term loan to repay outstanding borrowings under its ABL Facility. The incremental term loan was issued with 50 basis points of OID and has the same terms as, and is fungible with, the other term loans outstanding under the Term Loan Facility.

ABL Facility

The “ABL Facility” refers to the Company’s \$900 million asset-based loan revolving credit facility provided pursuant to the terms and provisions of that certain Fourth Amended and Restated ABL Credit Agreement dated as of June 14, 2016 (the “ABL Credit Agreement”) among the Company, the lenders party thereto from time to time, and JPMorgan Chase Bank, N.A., as administrative agent and collateral agent, as amended on September 27, 2017. All obligations under the ABL Facility are fully and unconditionally guaranteed, subject to certain customary release provisions, by substantially all of the Company’s wholly owned, domestic material subsidiaries, as well as certain other subsidiaries as the Company may determine from time to time in its sole discretion. As of December 31, 2017, \$156.0 million of letters of credit were outstanding under the ABL Facility.

The ABL Facility (1) matures on April 9, 2019, (2) contains financial maintenance covenants in the form of a minimum fixed charge coverage ratio and a maximum amount of annual capital expenditures, (3) imposes restrictions on the Company’s ability to incur debt and liens and make acquisitions, investments and payments on equity and junior debt, and (4) provides for interest rate

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 15 – LONG-TERM DEBT (Continued)

Credit Facilities (Continued)

ABL Facility (Continued)

margins of 2.00% to 2.50% for LIBOR borrowings and 1.00% to 1.50% for base rate borrowings (in each case depending on average daily excess availability), and (5) employs a borrowing base calculation to determine total available capacity thereunder.

A summary of the amendments to the ABL Facility since January 1, 2015 is set forth below.

On September 27, 2017, the Company entered into an amendment to the ABL Facility to update the provisions pertaining to letters of credit issued thereunder.

On June 14, 2016, the Company entered into the ABL Credit Agreement that amended and restated the ABL facility to provide for, among other things, (1) additional joint venture flexibility, including an increased ability to enter into and make investments in joint ventures that are non-guarantor restricted subsidiaries and to incur debt and liens of such joint ventures and other non-guarantor restricted subsidiaries, and (2) an increase in the size of a basket for asset sales from 15% to 25% of consolidated total assets.

On June 3, 2015, the Company entered into an amendment agreement to the ABL Facility that among other items, modified the restrictions on the amount of cash and temporary cash investments that may be held outside of certain deposit accounts subject to control agreements.

Gentiva Merger – Gentiva Financing Transactions

The following transactions (collectively, the “Gentiva Financing Transactions”) occurred in connection with the Gentiva Merger:

- the Company issued \$1.35 billion aggregate principal amount of the Notes (as defined below);
- the Company issued approximately 15 million shares of its Common Stock through two common stock offerings and issued 9.7 million shares of its Common Stock through the Stock Consideration (see Note 3);
- the Company issued 172,500 tangible equity units (see Note 16); and
- the Company amended its ABL Facility in October 2014 and Term Loan Facility in November 2014.

Notes due 2020 and Notes due 2023 Offerings

On December 18, 2014, Kindred Escrow Corp. II (the “Escrow Issuer”), one of the Company’s subsidiaries, completed a private placement of \$750 million aggregate principal amount of 8.00% Senior Notes due 2020 (the “Notes due 2020”) and \$600 million aggregate principal amount of 8.75% Senior Notes due 2023 (the “Notes due 2023”, and, together with the Notes due 2020, the “Notes”). The Notes due 2020 were issued pursuant to the indenture, dated as of December 18, 2014 (the “2020 Indenture”), between the Escrow Issuer and Wells Fargo Bank, National Association, as trustee. The Notes due 2023 were issued pursuant to the indenture, dated as of December 18, 2014 (the “2023 Indenture” and, together with the 2020 Indenture, the “Indentures”), between the Escrow Issuer and Wells Fargo Bank, National Association.

The Notes were assumed by the Company and fully and unconditionally guaranteed on a senior unsecured basis by substantially all of the Company’s wholly owned, domestic material subsidiaries, including substantially all of the Company’s and Gentiva’s wholly owned, domestic material subsidiaries (the “Guarantors”), ranking *pari passu* with all of the Company’s respective existing and future senior unsubordinated indebtedness. On October 30, 2015, the Company completed a registered exchange offer to exchange the Notes for registered notes with substantially identical terms.

The Indentures contain certain restrictive covenants that limit the Company and its restricted subsidiaries’ ability to, among other things, incur, assume or guarantee additional indebtedness; pay dividends, make distributions or redeem or repurchase capital stock; effect dividends, loans or asset transfers from its subsidiaries; sell or otherwise dispose of assets; and enter into transactions with affiliates. These covenants are subject to a number of limitations and exceptions. The Indentures also contain customary events of default.

Under the terms of the Indentures, the Company may pay dividends pursuant to specified exceptions, including if its consolidated coverage ratio (as defined therein) is at least 2.0 to 1.0, it may also pay dividends in an amount equal to 50% of its consolidated net income (as defined therein) and 100% of the net cash proceeds from the issuance of capital stock, in each case since January 1, 2014. The making of certain other restricted payments or investments by the Company or its restricted subsidiaries would reduce the amount available for the payment of dividends pursuant to the foregoing exception.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 15 – LONG-TERM DEBT (Continued)

Notes due 2022

On April 9, 2014, the Company completed a private placement of \$500 million aggregate principal amount of 6.375% senior notes due 2022 (the “Notes due 2022”). The Notes due 2022 were issued pursuant to the indenture dated April 9, 2014 (the “2022 Indenture”) among the Company, the guarantors party thereto (the “2022 Guarantors”) and Wells Fargo Bank, National Association, as trustee.

The Notes due 2022 bear interest at an annual rate of 6.375% and are senior unsecured obligations of the Company and the 2022 Guarantors. The 2022 Indenture contains certain restrictive covenants that, among other things, limits the Company and its restricted subsidiaries’ ability to incur, assume or guarantee additional indebtedness; pay dividends, make distributions or redeem or repurchase capital stock; effect dividends, loans or asset transfers from the Company’s subsidiaries; sell or otherwise dispose of assets; and enter into transactions with affiliates. These covenants are subject to a number of limitations and exceptions. The 2022 Indenture also contains customary events of default. The Notes due 2022 are fully and unconditionally guaranteed, subject to customary release provisions, by substantially all of the Company’s wholly owned, domestic material subsidiaries. On January 28, 2015, the Company completed a registered exchange offer to exchange each of the Notes due 2022 for registered notes with substantially identical terms.

Under the terms of the Notes due 2022, the Company may pay dividends pursuant to specified exceptions, including if its consolidated coverage ratio (as defined therein) is at least 2.0 to 1.0, the Company may pay dividends in an amount equal to 50% of its consolidated net income (as defined therein) and 100% of the net cash proceeds from the issuance of capital stock. The making of certain other restricted payments or investments by the Company or its restricted subsidiaries would reduce the amount available for the payment of dividends pursuant to the foregoing exception.

On January 30, 2015, following the receipt of sufficient consents to approve the proposed amendments, the Company, the 2022 Guarantors and Wells Fargo Bank, National Association, as trustee, entered into the first supplemental indenture (the “2022 Supplemental Indenture”) to the 2022 Indenture. The 2022 Supplemental Indenture conforms certain covenants, definitions and other terms in the 2022 Indenture to the covenants, definitions and terms contained in the Indentures governing the Notes. The 2022 Supplemental Indenture became operative following the consummation of the Gentiva Merger.

Interest rate swaps

In January 2016, the Company entered into three interest rate swap agreements to hedge its floating interest rate on an aggregate of \$325 million of outstanding Term Loan Facility debt, which replaced the previous \$225 million aggregate swap that expired on January 11, 2016. The interest rate swaps have an effective date of January 11, 2016, and expire on January 9, 2021. The Company is required to make payments based upon a fixed interest rate of 1.862% and 1.855% calculated on the notional amount of \$175 million and \$150 million, respectively. In exchange, the Company will receive interest on \$325 million at a variable interest rate that is based upon the three-month LIBOR rate, subject to a minimum rate of 1.0%.

In March 2014, the Company entered into an interest rate swap agreement to hedge its floating interest rate on an aggregate of \$400 million of outstanding Term Loan Facility debt. On April 8, 2014, the Company completed a novation of a portion of its \$400 million swap agreement to two new counterparties, each in the amount of \$125 million. The original swap contract was not amended, terminated or otherwise modified. The interest rate swap had an effective date of April 9, 2014 and will expire on April 9, 2018 and continues to apply to the Term Loan Facility. The Company is required to make payments based upon a fixed interest rate of 1.867% calculated on the notional amount of \$400 million. In exchange, the Company will receive interest on \$400 million at a variable interest rate that was based upon the three-month LIBOR, subject to a minimum rate of 1.0%.

The interest rate swaps were assessed for hedge effectiveness for accounting purposes and the Company determined the interest rate swaps qualify for cash flow hedge accounting treatment at December 31, 2017 and 2016. The Company records the effective portion of the gain or loss on these derivative financial instruments in accumulated other comprehensive income (loss) as a component of stockholders’ equity and records the ineffective portion of the gain or loss on these derivative financial instruments as interest expense. There was no ineffectiveness related to the interest rate swaps for the years ended December 31, 2017 and 2016. The ineffectiveness related to the interest rate swaps for the year ended December 31, 2015 was immaterial.

At December 31, 2017 and 2016, the aggregate fair value of the interest rate swaps was recorded in other current assets for \$2.5 million and in other accrued liabilities for \$2.7 million, respectively. The fair value was determined by reference to a third party valuation and is considered a Level 2 input within the fair value hierarchy.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 16 – TANGIBLE EQUITY UNITS

To finance the Gentiva Merger, the Company issued 172,500 tangible equity units (the “Units”). Each Unit was composed of a prepaid stock purchase contract (a “Purchase Contract”) and one share of 7.25% Mandatory Redeemable Preferred Stock, Series A (the “Mandatory Redeemable Preferred Stock”) having a final preferred stock installment payment date of December 1, 2017 and an initial liquidation preference of \$201.58 per share of Mandatory Redeemable Preferred Stock. On December 1, 2017, the remaining holders of 87,379 Purchase Contracts were mandatorily redeemed. As a result, holders thereof received 50.6329 shares of Common Stock per Purchase Contract, resulting in approximately 4.4 million shares of Common Stock being issued on such date. Holders of the Mandatory Redeemable Preferred Stock were previously entitled to receive a quarterly “preferred stock installment payment,” in cash, shares of Common Stock, or a combination thereof. The final preferred stock installment payment date was December 1, 2017, the same date that all shares of Mandatorily Redeemable Preferred Stock were redeemed as planned pursuant to their terms.

The Purchase Contracts were recorded as capital in excess of par value, net of issuance costs, and the Mandatory Redeemable Preferred Stock was recorded as long-term debt. Issuance costs associated with the Mandatory Redeemable Preferred Stock were recorded as deferred financing costs within long-term debt on the consolidated balance sheet and were amortized using the effective interest method as interest expense over the term of the instrument. On the issuance date, the Company allocated the proceeds of the Units to equity and debt based on the relative fair values of the respective components of each Unit. The aggregate values assigned upon issuance of each component of the Units were as follows (amounts in thousands except price per Unit):

	Purchase Contracts (equity component)	Mandatory Redeemable Preferred Stock (debt component)	Total
Price per Unit	\$ 798.42	\$ 201.58	\$ 1,000.00
Gross proceeds	\$ 137,727	\$ 34,773	\$ 172,500
Issuance costs	(4,938)	(1,247)	(6,185)
	<u>\$ 132,789</u>	<u>\$ 33,526</u>	<u>\$ 166,315</u>
Balance sheet impact at issuance:			
Long-term debt (deferred financing fees)	\$ -	\$ 1,247	\$ 1,247
Current portion of long-term debt	-	10,887	10,887
Long-term debt	-	23,886	23,886
Capital in excess of par value	132,789	-	132,789

Dividends on each share of Mandatory Redeemable Preferred Stock accumulated on the outstanding liquidation preference at a rate of 7.25% per annum. On March 1, June 1, September 1 and December 1 of each year, commencing on March 1, 2015, the Company paid equal quarterly cash installments of \$18.75 per share of Mandatory Redeemable Preferred Stock (except for the March 1, 2015 and June 1, 2016 installment payments, which were \$20.00 and \$18.76 per share of Mandatory Redeemable Preferred Stock, respectively). Each installment payment constituted a payment of dividends (recorded as interest expense) and a payment of consideration for the partial reduction in liquidation preference of the Mandatory Redeemable Preferred Stock.

Following the Gentiva Merger, the Company included the minimum number of shares to be issued under the Purchase Contracts in the denominator of the calculation of basic earnings per share. Diluted earnings per share, when applicable, included the weighted average number of common shares used in the basic denominator adjusted for the assumed number of shares that would be issued on the balance sheet date.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 17 – CONTINGENCIES

Management continually evaluates contingencies based upon the best available information. In addition, allowances for losses are provided currently for disputed items that have continuing significance, such as certain third party reimbursements and deductions that continue to be claimed in current cost reports and tax returns.

Management believes that allowances for losses have been provided to the extent necessary and that its assessment of contingencies is reasonable.

Principal contingencies are described below:

Revenues – Certain third party payments are subject to examination by agencies administering the various reimbursement programs. The Company is contesting certain issues raised in audits of prior year cost reports and the denial of payment by third parties to the Company's customers.

Professional liability risks – The Company has provided for losses for professional liability risks based upon management's best available information including actuarially determined estimates. Ultimate claims costs may differ from the provisions for loss. See Notes 7 and 12.

Legal and regulatory proceedings – The Company is a party to various legal actions and regulatory and other governmental and internal audits and investigations in the ordinary course of business (including investigations resulting from the Company's obligation to self-report suspected violations of law). The Company cannot predict the ultimate outcome of pending litigation and regulatory and other governmental and internal audits and investigations. The U.S. Department of Justice (the "DOJ"), CMS or other federal and state enforcement and regulatory agencies may conduct additional investigations related to the Company's businesses in the future. These matters could potentially subject the Company to sanctions, damages, recoupments, fines, and other penalties (some of which may not be covered by insurance), which may, either individually or in the aggregate, have a material adverse effect on the Company's business, financial position, results of operations, and liquidity. See Note 24.

Other indemnifications – In the ordinary course of business, the Company enters into contracts containing standard indemnification provisions and indemnifications specific to a transaction, such as a disposal of an operating facility. These indemnifications may cover claims related to employment-related matters, governmental regulations, environmental issues and tax matters, as well as patient, third party payor, supplier and contractual relationships. The Company also is subject to indemnity claims under contracts with its Kindred Rehabilitation Services division customers related to the provision of its services. Obligations under these indemnities generally are initiated by a breach of the terms of a contract or by a third party claim or event. These indemnifications could potentially subject the Company to damages and other payments which may, either individually or in the aggregate, have a material adverse effect on the Company's business, financial position, results of operations or liquidity.

Income taxes – The Company is subject to various federal and state income tax audits in the ordinary course of business. Such audits could result in increased tax payments, interest and penalties.

NOTE 18 – CAPITAL STOCK

Gentiva Merger – Stock Consideration

In connection with the Gentiva Merger, Kindred issued 9.7 million shares of Common Stock as part of the Gentiva Stock Consideration. See Note 3.

Units Offering

As of December 31, 2016, holders of 85,121 Purchase Contracts had elected early settlement. As a result, holders thereof received 43.0918 shares of Common Stock per Purchase Contract, resulting in approximately 3.7 million shares of Common Stock being issued by the Company. On December 1, 2017, the remaining holders of the 87,379 Purchase Contracts were mandatorily redeemed. As a result, holders thereof received 50.6329 shares of Common Stock per Purchase Contract, resulting in approximately 4.4 million shares of Common Stock being issued on such date. See Note 16.

Dividends and other payments

During 2017, the Company paid a cash dividend of \$0.12 per share of Common Stock on March 31, 2017 to shareholders of record as of the close of business on March 13, 2017. The Board elected to discontinue paying dividends on the Company's Common Stock following the March 31, 2017 payment and instead redirected funds to repay debt and invest in growth.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 18 – CAPITAL STOCK (Continued)

Dividends and other payments (Continued)

During 2016, the Company paid cash dividends of \$0.12 per share of Common Stock on each of the following dates: December 9, 2016, September 2, 2016, June 10, 2016 and April 1, 2016.

During 2015, the Company paid cash dividends of \$0.12 per share of Common Stock on each of the following dates: December 11, 2015, September 4, 2015, June 10, 2015 and April 1, 2015.

The Company made quarterly installment payments on the Units of \$18.75 per Unit on December 1, 2017 (to holders of record as of close of business on November 15, 2017), September 1, 2017, June 1, 2017 and March 1, 2017. The Company made installment payments on the Units of \$18.75 per Unit on December 1, 2016, September 1, 2016, March 1, 2016, December 1, 2015, September 1, 2015, June 1, 2015 and March 2, 2015 and of \$18.76 per Unit on June 1, 2016.

Equity compensation plans

In May 2011, the shareholders of the Company approved an additional three million shares of Common Stock issuable under the Company's incentive compensation plans to Company employees. In May 2014, the shareholders of the Company approved an additional 2.7 million shares of Common Stock issuable under the Company's incentive compensation plans to Company employees, and in February 2015, pursuant to an exception for shareholder approval under the exchange listing standards, the Company assumed an additional 1.4 million shares of Common Stock in connection with the Gentiva Merger, which shares are only issuable to legacy Gentiva employees or employees of the Company hired after February 2, 2015. In May 2017, the shareholders of the Company approved an additional five million shares of Common Stock issuable under the Company's incentive compensation plans to Company employees. In May 2012 and again in May 2015, the shareholders of the Company approved an additional 200,000 shares of Common Stock issuable under the Company's equity compensation plan to the Company's non-employee directors. In May 2017, the shareholders of the Company approved an additional 800,000 shares of Common Stock issuable under the Company's equity compensation plan to the Company's non-employee directors.

Plan descriptions

The Company maintains plans under which approximately 13 million service-based restricted shares, performance-based restricted shares, service-based restricted stock units and options to purchase Common Stock may be granted to directors, officers and other key employees. Exercise provisions vary, but most stock options are exercisable in whole or in part beginning one to four years after grant and ending seven to ten years after grant. Shares of Common Stock available for future grants were 4,901,301, 1,410,752 and 3,262,892 at December 31, 2017, 2016 and 2015, respectively.

Stock options

In conjunction with the Gentiva Merger, 1,075,965 stock options were assumed in 2015. There were no other stock option grants during 2017, 2016, and 2015.

Compensation expense related to stock options was immaterial for the year ended December 31, 2017, and approximated \$0.2 million (\$0.1 million net of income taxes) for the year ended December 31, 2016 and \$0.4 million (\$0.3 million net of income taxes) for the year ended December 31, 2015.

Activity in the various plans is summarized below:

	<u>Shares under option</u>	<u>Option price per share</u>	<u>Weighted average exercise price</u>
Balances, December 31, 2016	1,054,081	\$10.75 to \$27.79	\$ 23.58
Exercised	(2,973)	10.75 to 10.75	10.75
Canceled	(344,392)	10.75 to 27.18	21.89
Balances, December 31, 2017	<u>706,716</u>	\$10.75 to \$27.79	\$ 24.45

At December 31, 2017 the intrinsic value of the stock options exercised during 2017 and cash received from stock option exercises in 2017 was immaterial. No stock options were exercised during 2016. The intrinsic value of the stock options exercised during 2015 approximated \$0.3 million. Cash received from stock option exercises in 2015 totaled \$0.5 million.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 18 – CAPITAL STOCK (Continued)

Stock options (Continued)

A summary of stock options outstanding at December 31, 2017 follows:

Range of exercise prices	Options outstanding			Options exercisable	
	Number outstanding at December 31, 2017	Weighted average remaining contractual life	Weighted average exercise price	Number exercisable at December 31, 2017	Weighted average exercise price
\$10.75 to \$15.06	80,276	2 years	\$ 11.92	80,276	\$ 11.92
\$19.62	30,413	0.5 year	19.62	30,413	19.62
\$26.08 to \$27.79	596,027	0.8 year	26.39	596,027	26.39
	<u>706,716</u>	0.9 year	\$ 24.45	<u>706,716</u>	\$ 24.45

The intrinsic value of the stock options outstanding and stock options that are exercisable as of December 31, 2017 was zero.

Service-based restricted shares

At December 31, 2017, unearned compensation costs related to non-vested service-based restricted shares aggregated \$14.7 million. These costs will be expensed over the remaining weighted average vesting period of approximately two years. Compensation expense related to these awards approximated \$15.2 million (\$9.2 million net of income taxes) for the year ended December 31, 2017, \$14.2 million (\$8.6 million net of income taxes) for the year ended December 31, 2016 and \$13.6 million (\$8.2 million net of income taxes) for the year ended December 31, 2015.

A summary of non-vested service-based restricted shares follows:

	Non-vested service-based restricted shares	Weighted average fair value at date of grant
Balances, December 31, 2016	2,015,624	\$ 14.31
Granted	2,287,697	9.38
Vested	(894,086)	14.94
Canceled	(265,193)	12.07
Balances, December 31, 2017	<u>3,144,042</u>	\$ 10.73

The fair value of restricted shares vested during 2017, 2016 and 2015 was \$7.6 million, \$6.9 million and \$22.7 million, respectively.

Performance-based restricted shares

Performance-based restricted share awards vest over a three-year period based upon the attainment of various performance measures in each performance period. Compensation expense related to these awards approximated \$1.6 million (\$1.0 million net of income taxes) for the year ended December 31, 2017, \$1.0 million (\$0.6 million net of income taxes) for the year ended December 31, 2016 and \$5.8 million (\$3.5 million net of income taxes) for the year ended December 31, 2015.

A summary of non-vested performance-based restricted shares follows:

	Non-vested performance-based restricted shares	Weighted average fair value at date of grant
Balances, December 31, 2016	1,012,725	
Granted	938,401	\$ 8.55
Vested	(88,940)	11.67
Canceled	(440,096)	\$ 11.30
Balances, December 31, 2017	<u>1,422,090</u>	

The performance measures and fair value for each vesting period of a performance-based restricted share award are established annually. The performance measures and fair value for the non-vested performance-based restricted shares have not been established for vesting periods with performance measures determined after December 31, 2017.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 18 – CAPITAL STOCK (Continued)

Service-based restricted stock units

At December 31, 2017, unearned compensation related to non-vested service-based restricted stock units was immaterial. Compensation expense related to these awards approximated \$0.4 million (\$0.2 million net of income taxes) for the year ended December 31, 2017, \$1.0 million (\$0.6 million net of income taxes) for the year ended December 31, 2016 and \$0.8 million (\$0.5 million net of income taxes) for the year ended December 31, 2015.

A summary of non-vested service-based restricted stock units follows:

	Non-vested service-based restricted stock units	Weighted average fair value at date of grant
Balances, December 31, 2016	77,124	\$ 18.22
Vested	(59,432)	18.22
Balances, December 31, 2017	<u>17,692</u>	<u>\$ 18.22</u>

NOTE 19 – EMPLOYEE BENEFIT PLANS

The Company maintains defined contribution retirement plans covering employees who meet certain minimum eligibility requirements. Benefits are determined as a percentage of a participant's contributions and generally are vested based upon length of service. Retirement plan expense was \$4.4 million for 2017, \$5.1 million for 2016 and \$8.6 million for 2015. Amounts equal to retirement plan expense are funded annually.

NOTE 20 – BALANCE SHEET INFORMATION

Supplemental information related to the balance sheets at December 31 follows (in thousands):

	2017	2016
Other current assets:		
Prepaid assets	\$ 36,377	\$ 38,841
Other	24,233	24,852
	<u>60,610</u>	<u>63,693</u>
Other long-term assets:		
Reinsurance and other recoverables	\$ 200,682	\$ 213,580
Other	64,625	74,660
	<u>265,307</u>	<u>288,240</u>
Other accrued liabilities:		
Patient accounts	\$ 74,244	\$ 74,780
Accrued interest	73,839	71,919
Taxes other than income	26,375	32,359
Accrued acquisition and divestiture costs	24,872	2,569
Accrued room and board	16,064	15,888
Accrued litigation contingency	11,504	18,757
Other	37,079	48,240
	<u>263,977</u>	<u>264,512</u>
Deferred credits and other liabilities:		
Accrued workers compensation	\$ 201,002	\$ 216,971
Sale-leaseback financing obligation related to the SNF Divestiture (see Note 6)	140,790	-
Accrued lease termination fees	52,354	39,059
Straight line rent accruals	51,222	57,528
Other	52,586	39,736
	<u>\$ 497,954</u>	<u>\$ 353,294</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 21 – FINANCIAL INSTRUMENTS AND FAIR VALUE MEASUREMENTS

The Company follows the provisions of the authoritative guidance for fair value measurements, which addresses how companies should measure fair value when they are required to use a fair value measure for recognition or disclosure purposes under GAAP.

Fair value is defined as the exchange price that would be received for an asset or paid to transfer a liability in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. The guidance related to fair value measures establishes a fair value hierarchy that requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The guidance describes three levels of inputs that may be used to measure fair value:

- Level 1** Quoted prices in active markets for identical assets or liabilities. Level 1 assets and liabilities include debt and equity securities and derivative contracts that are traded in an active exchange market, as well as certain U.S. Treasury, other U.S. Government and agency asset backed debt securities that are highly liquid and are actively traded in over-the-counter markets.
- Level 2** Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, and other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.
- Level 3** Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities. Level 3 assets and liabilities include financial instruments whose value is determined using pricing models, discounted cash flow methodologies, or similar techniques, as well as instruments for which the determination of fair value requires significant management judgment or estimation.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 21 – FINANCIAL INSTRUMENTS AND FAIR VALUE MEASUREMENTS (Continued)

The Company's assets and liabilities measured at fair value on a recurring and non-recurring basis and any associated losses for the years ended December 31, 2017 and 2016 are summarized below (in thousands):

	Fair value measurements			Assets/liabilities at fair value	Total losses
	Level 1	Level 2	Level 3		
December 31, 2017					
Recurring:					
Assets:					
Deposits held in money market funds	\$ 17,012	\$ -	\$ -	\$ 17,012	\$ -
Money market funds	6,354	-	-	6,354	-
Interest rate swaps	-	2,508	-	2,508	-
	<u>\$ 23,366</u>	<u>\$ 2,508</u>	<u>\$ -</u>	<u>\$ 25,874</u>	<u>\$ -</u>
Liabilities:					
Contingent consideration liability	<u>\$ -</u>	<u>\$ -</u>	<u>\$ (3,375)</u>	<u>\$ (3,375)</u>	<u>\$ -</u>
Non-recurring:					
Assets:					
Property and equipment	\$ -	\$ -	\$ 327,400	\$ 327,400	\$ (2,062)
Goodwill	-	-	125,045	125,045	(236,265)
Intangible assets - Kindred at Home	-	-	19,795	19,795	(3,501)
Intangible assets - Hospitals	-	-	-	-	(3,804)
Intangible assets - Kindred Rehabilitation Services	-	-	500	500	(135,188)
Kindred at Home building available for sale	-	-	-	-	(474)
Hospitals available for sale	-	-	15,430	15,430	(1,153)
	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 488,170</u>	<u>\$ 488,170</u>	<u>\$ (382,447)</u>
Liabilities					
	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>
December 31, 2016					
Recurring:					
Assets:					
Available-for-sale debt securities:					
Corporate bonds	\$ -	\$ 55,176	\$ -	\$ 55,176	\$ -
Debt securities issued by U.S. government agencies	-	18,288	-	18,288	-
U.S. Treasury notes	24,727	-	-	24,727	-
	<u>24,727</u>	<u>73,464</u>	<u>-</u>	<u>98,191</u>	<u>-</u>
Available-for-sale equity securities	15,688	-	-	15,688	-
Money market funds	16,472	-	-	16,472	-
Certificates of deposit	-	14,864	-	14,864	-
Total available-for-sale investments	56,887	88,328	-	145,215	-
Deposits held in money market funds	100	4,126	-	4,226	-
	<u>\$ 56,987</u>	<u>\$ 92,454</u>	<u>\$ -</u>	<u>\$ 149,441</u>	<u>\$ -</u>
Liabilities:					
Contingent consideration liability	\$ -	\$ -	\$ (4,943)	\$ (4,943)	\$ -
Interest rate swaps	-	(2,718)	-	(2,718)	-
	<u>\$ -</u>	<u>\$ (2,718)</u>	<u>\$ (4,943)</u>	<u>\$ (7,661)</u>	<u>\$ -</u>
Non-recurring:					
Assets:					
Property and equipment	\$ -	\$ -	\$ 650,222	\$ 650,222	\$ (31,029)
Goodwill	-	-	361,310	361,310	(261,129)
Intangible assets - Kindred at Home	-	-	19,010	19,010	(3,534)
Intangible assets - Hospitals	-	-	641	641	(3,559)
Hospitals available for sale	-	-	-	-	(43,308)
	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 1,031,183</u>	<u>\$ 1,031,183</u>	<u>\$ (342,559)</u>
Liabilities					
	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 21 – FINANCIAL INSTRUMENTS AND FAIR VALUE MEASUREMENTS (Continued)

Recurring measurements

The Company's available-for-sale investments held by Comerstone consist of debt securities, money market funds and certificates of deposit. These available-for-sale investments and the insurance subsidiary's cash and cash equivalents of \$46.6 million as of December 31, 2017 and \$170.3 million as of December 31, 2016, classified as insurance subsidiary investments, are maintained for the payment of claims and expenses related to professional liability and workers compensation risks. In connection with the Insurance Restructuring, the Company liquidated a significant portion of its insurance subsidiary investments and released cash back to the parent company to repay debt and increase cash reserves.

The Company also has available-for-sale investments totaling \$1.4 million as of December 31, 2017 and \$1.7 million as of December 31, 2016 related to a deferred compensation plan that is maintained for certain of the Company's current and former employees.

The fair value of actively traded debt and money market funds is based upon quoted market prices and are generally classified as Level 1. The fair value of inactively traded debt securities and certificates of deposit is based upon either quoted market prices of similar securities or observable inputs such as interest rates using either a market or income valuation approach and are generally classified as Level 2. The Company's investment advisors obtain and review pricing for each security. The Company is responsible for the determination of fair value and as such the Company reviews the pricing information from its advisors in determining reasonable estimates of fair value. Based upon the Company's internal review procedures, there were no adjustments to the prices during 2017 or 2016.

The Company's deposits held in money market funds consist primarily of cash and cash equivalents for the Company's general corporate purposes.

The Company acquired a contingent consideration liability in the Gentiva Merger from a prior acquisition by Gentiva with an initial estimated fair value of \$7.9 million. The fair value is determined using a discounted cash flow approach utilizing Level 2 and Level 3 inputs which includes observable market discount rates, fixed payment schedules, and assumptions based on achieving certain predefined performance criteria. As of December 31, 2017, the fair value of the contingent consideration liability was \$3.4 million. The change in fair value for the year ended December 31, 2017 consists of \$1.8 million in payments and \$0.2 million in accrued interest included in interest expense in the accompanying consolidated statement of operations. A one percent change in the discount rate used to calculate the accretion of the present value of the contingent consideration liability would have an impact on the fair value of approximately \$0.1 million.

The fair value of the derivative asset or liability associated with the interest rate swaps is estimated using industry-standard valuation models, which are Level 2 measurements. Such models project future cash flows and discount the future amounts to a present value using market-based observable inputs, including interest rate curves. See Note 15.

The following table presents the carrying amounts and estimated fair values of the Company's financial instruments. The carrying value is equal to fair value for financial instruments that are based upon quoted market prices or current market rates. The Company's long-term debt is based upon Level 2 inputs.

(In thousands)	December 31, 2017		December 31, 2016	
	Carrying value	Fair value	Carrying value	Fair value
Cash and cash equivalents	\$ 160,254	\$ 160,254	\$ 137,061	\$ 137,061
Insurance subsidiary investments	51,534	51,534	313,895	313,895
Long-term debt, including amounts due within one year (excluding capital lease obligations totaling \$0.3 million and \$0.6 million at December 31, 2017 and December 31, 2016, respectively)	3,161,298	3,316,136	3,242,459	3,220,291

Non-recurring measurements

During the fourth quarter of 2017, the Company recorded a hospital division reporting unit goodwill impairment charge of \$236.3 million in connection with its annual impairment test performed as of October 1, 2017. The impairment was required after cash flow projections and related mitigation strategies were refined after completing the first full year of operations under the LTAC Legislation. The refinement of the projections and mitigation strategies were finalized over the last three months of 2017 in connection with the preparation of the Company's annual budget for 2018. The Company also tested the carrying value of its hospital division intangible assets and property and equipment and determined impairment charges of \$3.2 million for a Medicare license and \$0.8 million for property and equipment were also necessary. The fair value of the assets was measured using Level 3 inputs, such as operating cash flows, market data and replacement cost factoring in depreciation, economic obsolescence and inflation trends.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 21 – FINANCIAL INSTRUMENTS AND FAIR VALUE MEASUREMENTS (Continued)

Non-recurring measurements (Continued)

During the fourth quarter of 2017, the Company also recorded an asset impairment charge of \$3.5 million related to previously acquired home health and hospice certificates of need as part of the annual indefinite-lived intangible assets impairment review at October 1, 2017. The fair value of the certificates of need was measured using Level 3 inputs, such as operating cash flows.

During the fourth quarter of 2017, the Company also recorded asset impairment charges of \$1.1 million related to property and equipment of the planned sale of two hospitals. The fair value of the property and equipment was measured using Level 3 inputs, primarily replacement cost and a pending offer.

During the year ended December 31, 2017, the Company recorded asset impairment charges of \$134.6 million related to the previously acquired RehabCare trade name (\$97.4 million) and customer relationship intangible asset (\$37.2 million) due to the expected loss of affiliated contracts related to the SNF Divestiture and cancellation of non-affiliated contracts. The fair value of the trade name was measured using Level 3 inputs, such as projected revenues and royalty rate. The fair value of the customer relationship intangible asset was measured using Level 3 inputs, such as discounted projected future operating cash flows.

During the year ended December 31, 2017, the Company also recorded asset impairment charges of \$1.3 million related to a hospital certificate of need (\$0.7 million) and a Medicare certification for an IRF (\$0.6 million) as part of the annual indefinite-lived intangible assets impairment review at May 1, 2017. The fair value of the certificate of need was measured using Level 3 inputs, such as operating cash flows. The fair value of the Medicare certification was measured using a pending offer, a Level 3 input.

During the year ended December 31, 2017, the Company recorded an asset impairment charge of \$0.4 million related to a valuation adjustment for a building within the Kindred at Home division. The fair value of the building was measured using Level 3 inputs, primarily replacement cost.

During the year ended December 31, 2017, the Company recorded an asset impairment charge of \$1.3 million related to the SNF Divestiture which is recorded in discontinued operations. The fair value of property and equipment was measured using Level 3 inputs, primarily replacement costs.

During the fourth quarter of 2016, the Company recorded an asset impairment charge of \$3.6 million related to previously acquired home health and hospice Medicare certifications, certificates of need and a trade name, as part of the annual indefinite-lived intangible assets impairment review at October 1, 2016. The fair value of the assets was measured using Level 3 unobservable inputs, such as projected revenue and operating cash flows.

During the year ended December 31, 2016, the Company recorded a goodwill impairment charge of \$261.1 million and a property and equipment impairment charge of \$3.2 million related to the Hospital Division Triggering Event. The fair value of the assets was measured using Level 3 inputs such as operating cash flows, market data and replacement cost factoring in depreciation, economic obsolescence and inflation trends.

During the year ended December 31, 2016, the Company recorded impairment charges aggregating \$33.0 million, comprised of \$19.7 million related to property and equipment, and \$13.3 million related to goodwill and other intangible assets related to the Curahealth Disposal. The fair value of the assets was measured using a Level 3 input of the offer pending from Curahealth at September 30, 2016. The properties were subsequently sold during the fourth quarter of 2016. In addition, during the first quarter of 2016, the Company recorded asset impairment charges of \$7.8 million under the held and used accounting model related to the planned Curahealth Disposal. The fair value of property and equipment was measured in the first quarter of 2016 using Level 3 inputs, primarily replacement costs.

During the year ended December 31, 2016, the Company reviewed the long-lived assets related to the decline in financial performance of its nursing center division. After determining it was more likely than not that the Company would dispose of its skilled nursing facility business, the Company determined that its property and equipment was impaired. As a result, the Company recorded an impairment charge of \$22.5 million which is recorded in discontinued operations. The fair value of the assets was measured using Level 3 inputs, such as operating cash flows and replacement costs.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 21 – FINANCIAL INSTRUMENTS AND FAIR VALUE MEASUREMENTS (Continued)

Non-recurring measurements (Continued)

During the year ended December 31, 2016, the Company reviewed the long-lived assets related to the planned divestiture and pending offers for a nursing center held for sale and determined its property and equipment was impaired. As a result, the Company recorded an impairment charge of \$5.3 million which is recorded in discontinued operations. The fair value of the assets was measured based upon pending offers, a Level 3 input.

During the year ended December 31, 2016, the Company recorded an asset impairment charge of \$2.6 million related to the sale of a hospital division medical office building. The fair value of the property was measured using a Level 3 input of the then pending offer.

During the year ended December 31, 2016, the Company also recorded an impairment charge of \$3.5 million related to certificates of need for two hospitals as part of the annual indefinite-lived intangible assets impairment review at May 1, 2016. The fair value of the certificates of need was measured using Level 3 inputs, such as operating cash flows.

Each of the impairment charges discussed above reflects the amount by which the carrying value of the assets exceeded its estimated fair value at each impairment date.

NOTE 22 – NONCONTROLLING INTERESTS

As of December 31, 2017, the Company had ownership ranging from 40% to 99% in various partnerships. During 2017 and 2015, the Company did not complete any buyouts of noncontrolling interests. During 2016, the Company completed a full joint venture buyout of a noncontrolling interest as detailed in the table below (in thousands). In accordance with the authoritative guidance of noncontrolling interests, this payment has been accounted for as an equity transaction.

Decrease in carrying value of noncontrolling interests for purchase of noncontrolling interest in subsidiary	\$ 766
Decrease in Company's capital in excess of par value for purchase of noncontrolling interest in subsidiary	234
Total cash consideration paid in exchange for purchase of noncontrolling interest	<u>\$ 1,000</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 23 – CONDENSED CONSOLIDATING FINANCIAL INFORMATION

The accompanying condensed consolidating financial information has been prepared and presented pursuant to the Securities and Exchange Commission Regulation S-X, Rule 3-10, “Financial Statements of Guarantors and Issuers of Guaranteed Securities Registered or Being Registered.” The Company’s Notes due 2020, Notes due 2022 and Notes due 2023 are fully and unconditionally guaranteed by substantially all of the Company’s domestic 100% owned subsidiaries. The Company’s Notes due 2020 and the Notes due 2023, which were issued during 2014, were senior unsecured obligations of the Escrow Issuer, which, prior to the Gentiva Merger, was a non-guarantor subsidiary of the Company. In connection with the Gentiva Merger, the Escrow Issuer was merged with and into the Company, with the Company assuming the Notes due 2020 and Notes due 2023. See Note 15. The equity method has been used with respect to the parent company’s investment in subsidiaries.

The following condensed consolidating financial data present the financial position of the parent company/issuer, the guarantor subsidiaries and the non-guarantor subsidiaries as of December 31, 2017 and December 31, 2016, and the respective results of operations and cash flows for the three years ended December 31, 2017.

Condensed Consolidating Statement of Operations and Comprehensive Loss

(In thousands)	Year ended December 31, 2017				
	Parent company/ issuer	Guarantor subsidiaries	Non-guarantor subsidiaries	Consolidating and eliminating adjustments	Consolidated
Revenues	\$ -	\$ 5,360,982	\$ 673,141	\$ -	\$ 6,034,123
Salaries, wages and benefits	-	3,061,104	257,781	-	3,318,885
Supplies	-	264,294	39,629	-	303,923
Building rent	-	204,358	53,158	-	257,516
Equipment rent	-	29,732	5,124	-	34,856
Other operating expenses	-	585,579	55,185	-	640,764
General and administrative expenses	-	936,899	132,865	-	1,069,764
Other income	-	(478)	(2,982)	-	(3,460)
Litigation contingency expense	-	7,435	-	-	7,435
Impairment charges	-	279,829	101,350	-	381,179
Restructuring charges	-	84,112	749	-	84,861
Depreciation and amortization	-	95,286	9,519	-	104,805
Management fees	-	(8,767)	8,767	-	-
Intercompany interest (income) expense from affiliates	(179,511)	127,459	52,052	-	-
Interest expense (income)	242,398	(1,039)	52	-	241,411
Investment income	-	(368)	(3,131)	-	(3,499)
Equity in net loss of consolidating affiliates	635,465	-	-	(635,465)	-
	<u>698,352</u>	<u>5,665,435</u>	<u>710,118</u>	<u>(635,465)</u>	<u>6,438,440</u>
Loss from continuing operations before income taxes	(698,352)	(304,453)	(36,977)	635,465	(404,317)
Provision (benefit) for income taxes	-	(165,254)	8,138	-	(157,116)
Loss from continuing operations	(698,352)	(139,199)	(45,115)	635,465	(247,201)
Discontinued operations, net of income taxes:					
Income (loss) from operations	-	(29,725)	12,871	-	(16,854)
Loss on divestiture of operations	-	(379,260)	-	-	(379,260)
Income (loss) from discontinued operations	-	(408,985)	12,871	-	(396,114)
Net loss	(698,352)	(548,184)	(32,244)	635,465	(643,315)
Earnings attributable to noncontrolling interests:					
Continuing operations	-	-	(42,176)	-	(42,176)
Discontinued operations	-	-	(12,861)	-	(12,861)
	-	-	(55,037)	-	(55,037)
Loss attributable to Kindred	<u>\$ (698,352)</u>	<u>\$ (548,184)</u>	<u>\$ (87,281)</u>	<u>\$ 635,465</u>	<u>\$ (698,352)</u>
Comprehensive loss	<u>\$ (693,746)</u>	<u>\$ (548,142)</u>	<u>\$ (32,296)</u>	<u>\$ 635,475</u>	<u>\$ (638,709)</u>
Comprehensive loss attributable to Kindred	<u>\$ (693,746)</u>	<u>\$ (548,142)</u>	<u>\$ (87,333)</u>	<u>\$ 635,475</u>	<u>\$ (693,746)</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 23 – CONDENSED CONSOLIDATING FINANCIAL INFORMATION (Continued)

Condensed Consolidating Statement of Operations and Comprehensive Loss (Continued)

(In thousands)	Year ended December 31, 2016				
	Parent company/ issuer	Guarantor subsidiaries	Non-guarantor subsidiaries	Consolidating and eliminating adjustments	Consolidated
Revenues	\$ -	\$ 5,625,662	\$ 768,982	\$ (102,115)	\$ 6,292,529
Salaries, wages and benefits	-	3,143,055	249,208	-	3,392,263
Supplies	-	299,919	43,146	-	343,065
Building rent	-	209,313	54,993	-	264,306
Equipment rent	-	34,372	5,557	-	39,929
Other operating expenses	-	597,226	59,566	-	656,792
General and administrative expenses	-	981,470	228,293	(102,115)	1,107,648
Other income	-	(2,091)	(2,975)	-	(5,066)
Litigation contingency expense	-	2,840	-	-	2,840
Impairment charges	-	193,057	121,672	-	314,729
Restructuring charges	-	94,108	2,018	-	96,126
Depreciation and amortization	-	122,522	9,297	-	131,819
Management fees	-	(8,862)	8,862	-	-
Intercompany interest (income) expense from affiliates	(222,445)	177,578	44,867	-	-
Interest expense (income)	234,630	(129)	111	-	234,612
Investment income	-	(453)	(2,655)	-	(3,108)
Equity in net loss of consolidating affiliates	656,019	-	-	(656,019)	-
	<u>668,204</u>	<u>5,843,925</u>	<u>821,960</u>	<u>(758,134)</u>	<u>6,575,955</u>
Loss from continuing operations before income taxes	(668,204)	(218,263)	(52,978)	656,019	(283,426)
Provision (benefit) for income taxes	(3,974)	308,700	9,536	-	314,262
Loss from continuing operations	(664,230)	(526,963)	(62,514)	656,019	(597,688)
Discontinued operations, net of income taxes:					
Income (loss) from operations	-	(25,111)	18,919	-	(6,192)
Loss on divestiture of operations	-	(6,744)	-	-	(6,744)
Income (loss) from discontinued operations	-	(31,855)	18,919	-	(12,936)
Net loss	(664,230)	(558,818)	(43,595)	656,019	(610,624)
Earnings attributable to noncontrolling interests:					
Continuing operations	-	-	(34,847)	-	(34,847)
Discontinued operations	-	-	(18,759)	-	(18,759)
	-	-	(53,606)	-	(53,606)
Loss attributable to Kindred	\$ (664,230)	\$ (558,818)	\$ (97,201)	\$ 656,019	\$ (664,230)
Comprehensive loss	\$ (660,025)	\$ (558,598)	\$ (43,255)	\$ 655,459	\$ (606,419)
Comprehensive loss attributable to Kindred	\$ (660,025)	\$ (558,598)	\$ (96,861)	\$ 655,459	\$ (660,025)

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 23 – CONDENSED CONSOLIDATING FINANCIAL INFORMATION (Continued)

Condensed Consolidating Statement of Operations and Comprehensive Income (Loss) (Continued)

	Year ended December 31, 2015				
(In thousands)	Parent company/ issuer	Guarantor subsidiaries	Non-guarantor subsidiaries	Consolidating and eliminating adjustments	Consolidated
Revenues	\$ -	\$ 5,507,709	\$ 714,383	\$ (102,874)	\$ 6,119,218
Salaries, wages and benefits	-	3,000,718	232,329	-	3,233,047
Supplies	-	299,846	42,229	-	342,075
Building rent	-	206,717	50,504	-	257,221
Equipment rent	-	33,767	4,823	-	38,590
Other operating expenses	-	585,522	54,086	-	639,608
General and administrative expenses	-	1,092,613	221,048	(102,874)	1,210,787
Other (income) expense	-	744	(3,102)	-	(2,358)
Litigation contingency expense	-	138,648	-	-	138,648
Impairment charges	-	24,757	-	-	24,757
Restructuring charges	-	12,618	-	-	12,618
Depreciation and amortization	-	120,238	9,008	-	129,246
Management fees	-	(19,904)	19,904	-	-
Intercompany interest (income) expense from affiliates	(205,411)	160,201	45,210	-	-
Interest expense	228,826	3,176	349	-	232,351
Investment income	-	(1,609)	(1,147)	-	(2,756)
Equity in net loss of consolidating affiliates	79,183	-	-	(79,183)	-
	<u>102,598</u>	<u>5,658,052</u>	<u>675,241</u>	<u>(182,057)</u>	<u>6,253,834</u>
Income (loss) from continuing operations before income taxes	(102,598)	(150,343)	39,142	79,183	(134,616)
Provision (benefit) for income taxes	(9,214)	(50,084)	7,584	-	(51,714)
Income (loss) from continuing operations	(93,384)	(100,259)	31,558	79,183	(82,902)
Discontinued operations, net of income taxes:					
Income from operations	-	15,273	15,531	-	30,804
Gain on divestiture of operations	-	1,244	-	-	1,244
Income from discontinued operations	-	16,517	15,531	-	32,048
Net income (loss)	(93,384)	(83,742)	47,089	79,183	(50,854)
Earnings attributable to noncontrolling interests:					
Continuing operations	-	-	(26,044)	-	(26,044)
Discontinued operations	-	-	(16,486)	-	(16,486)
	-	-	(42,530)	-	(42,530)
Income (loss) attributable to Kindred	<u>\$ (93,384)</u>	<u>\$ (83,742)</u>	<u>\$ 4,559</u>	<u>\$ 79,183</u>	<u>\$ (93,384)</u>
Comprehensive income (loss)	<u>\$ (93,465)</u>	<u>\$ (83,286)</u>	<u>\$ 46,890</u>	<u>\$ 78,926</u>	<u>\$ (50,935)</u>
Comprehensive income (loss) attributable to Kindred	<u>\$ (93,465)</u>	<u>\$ (83,286)</u>	<u>\$ 4,360</u>	<u>\$ 78,926</u>	<u>\$ (93,465)</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 23 – CONDENSED CONSOLIDATING FINANCIAL INFORMATION (Continued)

Condensed Consolidating Balance Sheet

	As of December 31, 2017				
(In thousands)	Parent company/ issuer	Guarantor subsidiaries	Non-guarantor subsidiaries	Consolidating and eliminating adjustments	Consolidated
ASSETS					
Current assets:					
Cash and cash equivalents	\$ -	\$ 40,893	\$ 119,361	\$ -	\$ 160,254
Insurance subsidiary investments	-	-	22,546	-	22,546
Accounts receivable, net	-	993,907	128,625	-	1,122,532
Inventories	-	17,714	4,002	-	21,716
Income taxes	-	3,467	1,079	-	4,546
Assets held for sale	-	16,555	780	-	17,335
Other	2,508	51,980	6,122	-	60,610
	<u>2,508</u>	<u>1,124,516</u>	<u>282,515</u>	<u>-</u>	<u>1,409,539</u>
Property and equipment, net	-	682,276	53,703	-	735,979
Goodwill	-	1,839,845	348,721	-	2,188,566
Intangible assets, net	-	558,827	45,511	-	604,338
Insurance subsidiary investments	-	-	28,988	-	28,988
Investment in subsidiaries	3,405,029	-	-	(3,405,029)	-
Intercompany receivable	-	691,980	-	(691,980)	-
Deferred tax assets	-	-	1,036	(1,036)	-
Other	5,699	112,808	146,800	-	265,307
	<u>\$ 3,413,236</u>	<u>\$ 5,010,252</u>	<u>\$ 907,274</u>	<u>\$ (4,098,045)</u>	<u>\$ 5,232,717</u>
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	\$ -	\$ 133,031	\$ 58,796	\$ -	\$ 191,827
Salaries, wages and other compensation	-	334,729	17,450	-	352,179
Due to third party payors	-	35,269	52	-	35,321
Professional liability risks	-	46,274	14,493	-	60,767
Accrued lease termination fees	-	7,610	-	-	7,610
Other accrued liabilities	73,840	172,402	17,735	-	263,977
Long-term debt due within one year	14,034	-	604	-	14,638
	<u>87,874</u>	<u>729,315</u>	<u>109,130</u>	<u>-</u>	<u>926,319</u>
Long-term debt	3,146,594	-	378	-	3,146,972
Intercompany payable	55,442	-	636,538	(691,980)	-
Professional liability risks	-	142,479	134,350	-	276,829
Deferred tax liabilities	-	37,917	-	(1,036)	36,881
Deferred credits and other liabilities	-	434,105	63,849	-	497,954
Commitments and contingencies					
Equity (deficit):					
Stockholder's equity (deficit)	123,326	3,666,436	(261,407)	(3,405,029)	123,326
Noncontrolling interests	-	-	224,436	-	224,436
	<u>123,326</u>	<u>3,666,436</u>	<u>(36,971)</u>	<u>(3,405,029)</u>	<u>347,762</u>
	<u>\$ 3,413,236</u>	<u>\$ 5,010,252</u>	<u>\$ 907,274</u>	<u>\$ (4,098,045)</u>	<u>\$ 5,232,717</u>

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 23 – CONDENSED CONSOLIDATING FINANCIAL INFORMATION (Continued)

Condensed Consolidating Balance Sheet (Continued)

(In thousands)	As of December 31, 2016				
	Parent company/ issuer	Guarantor subsidiaries	Non-guarantor subsidiaries	Consolidating and eliminating adjustments	Consolidated
ASSETS					
Current assets:					
Cash and cash equivalents	\$ -	\$ 25,767	\$ 111,294	\$ -	\$ 137,061
Insurance subsidiary investments	-	-	108,966	-	108,966
Accounts receivable, net	-	1,022,850	149,228	-	1,172,078
Inventories	-	18,290	4,148	-	22,438
Income taxes	-	9,023	1,044	-	10,067
Assets held for sale	-	278,689	10,761	-	289,450
Other	-	56,054	7,639	-	63,693
	-	1,410,673	393,080	-	1,803,753
Property and equipment, net	-	557,761	60,859	-	618,620
Goodwill	-	1,977,003	450,071	-	2,427,074
Intangible assets, net	-	723,760	46,348	-	770,108
Insurance subsidiary investments	-	-	204,929	-	204,929
Intercompany	4,850,517	-	-	(4,850,517)	-
Deferred tax assets	-	-	7,224	(7,224)	-
Other	10,123	116,305	161,812	-	288,240
	\$ 4,860,640	\$ 4,785,502	\$ 1,324,323	\$ (4,857,741)	\$ 6,112,724
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	\$ -	\$ 112,286	\$ 91,639	\$ -	\$ 203,925
Salaries, wages and other compensation	-	339,600	57,886	-	397,486
Due to third party payors	-	41,320	-	-	41,320
Professional liability risks	-	3,401	61,883	-	65,284
Accrued lease termination fees	-	5,224	-	-	5,224
Other accrued liabilities	74,634	170,476	19,402	-	264,512
Long-term debt due within one year	26,406	-	1,571	-	27,977
	101,040	672,307	232,381	-	1,005,728
Long-term debt	3,214,607	-	455	-	3,215,062
Intercompany/deficiency in earnings of consolidated subsidiaries	732,442	4,281,685	568,832	(5,582,959)	-
Professional liability risks	-	78,124	217,187	-	295,311
Deferred tax liabilities	-	209,032	-	(7,224)	201,808
Deferred credits and other liabilities	-	219,701	133,593	-	353,294
Commitments and contingencies					
Equity (deficit):					
Stockholder's equity (deficit)	812,551	(675,347)	(57,095)	732,442	812,551
Noncontrolling interests	-	-	228,970	-	228,970
	812,551	(675,347)	171,875	732,442	1,041,521
	\$ 4,860,640	\$ 4,785,502	\$ 1,324,323	\$ (4,857,741)	\$ 6,112,724

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 23 – CONDENSED CONSOLIDATING FINANCIAL INFORMATION (Continued)

Condensed Consolidating Statement of Cash Flows

(In thousands)	Year ended December 31, 2017				
	Parent company/ issuer	Guarantor subsidiaries	Non-guarantor subsidiaries	Consolidating and eliminating adjustments	Consolidated
Net cash provided by (used in) operating activities	\$ (50,748)	\$ 268,325	\$ (141,882)	\$ -	\$ 75,695
Cash flows from investing activities:					
Routine capital expenditures	-	(67,222)	(2,584)	-	(69,806)
Development capital expenditures	-	(25,895)	-	-	(25,895)
Acquisitions, net of cash acquired	-	(9,650)	-	-	(9,650)
Sale of assets, net of lease termination charges	-	(71,555)	-	-	(71,555)
Purchase of insurance subsidiary investments	-	-	(113,661)	-	(113,661)
Sale of insurance subsidiary investments	-	-	243,616	-	243,616
Net change in insurance subsidiary cash and cash equivalents	-	-	133,618	-	133,618
Net change in other investments	-	24,637	-	-	24,637
Return of contributed surplus from Cornerstone	-	43,000	-	(43,000)	-
Other	-	7	-	-	7
Net cash provided by (used in) investing activities	-	(106,678)	260,989	(43,000)	111,311
Cash flows from financing activities:					
Proceeds from borrowings under revolving credit	1,369,700	-	-	-	1,369,700
Repayment of borrowings under revolving credit	(1,432,200)	-	-	-	(1,432,200)
Repayment of term loan	(14,034)	-	-	-	(14,034)
Repayment of other long-term debt	-	-	(1,045)	-	(1,045)
Payment of deferred financing costs	(413)	-	-	-	(413)
Issuance of Common Stock in connection with employee benefit plans	32	-	-	-	32
Payment of dividend for Mandatory Redeemable Preferred Stock	(12,372)	-	-	-	(12,372)
Dividends paid	(10,228)	-	-	-	(10,228)
Contributions made by noncontrolling interests	-	-	505	-	505
Distributions to noncontrolling interests	-	-	(61,226)	-	(61,226)
Payroll tax payments for equity awards issuance	-	(2,532)	-	-	(2,532)
Return of contributed surplus from Cornerstone	-	-	(43,000)	43,000	-
Net change in intercompany accounts	150,263	(143,989)	(6,274)	-	-
Net cash provided by (used in) financing activities	50,748	(146,521)	(111,040)	43,000	(163,813)
Change in cash and cash equivalents	-	15,126	8,067	-	23,193
Cash and cash equivalents at beginning of period	-	25,767	111,294	-	137,061
Cash and cash equivalents at end of period	\$ -	\$ 40,893	\$ 119,361	\$ -	\$ 160,254

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 23 – CONDENSED CONSOLIDATING FINANCIAL INFORMATION (Continued)

Condensed Consolidating Statement of Cash Flows (Continued)

(In thousands)	Year ended December 31, 2016				
	Parent company/ issuer	Guarantor subsidiaries	Non-guarantor subsidiaries	Consolidating and eliminating adjustments	Consolidated
Net cash provided by (used in) operating activities	\$ (630)	\$ 93,641	\$ 95,225	\$ -	\$ 188,236
Cash flows from investing activities:					
Routine capital expenditures	-	(88,875)	(7,177)	-	(96,052)
Development capital expenditures	-	(14,060)	(20,765)	-	(34,825)
Acquisitions, net of cash acquired	-	(78,840)	-	-	(78,840)
Acquisition deposits	-	18,489	-	-	18,489
Sale of assets	-	25,987	-	-	25,987
Purchase of insurance subsidiary investments	-	-	(97,740)	-	(97,740)
Sale of insurance subsidiary investments	-	-	95,488	-	95,488
Net change in insurance subsidiary cash and cash equivalents	-	-	877	-	877
Net change in other investments	-	(34,521)	1,751	-	(32,770)
Other	-	(255)	-	-	(255)
Net cash used in investing activities	-	(172,075)	(27,566)	-	(199,641)
Cash flows from financing activities:					
Proceeds from borrowings under revolving credit	1,643,300	-	-	-	1,643,300
Repayment of borrowings under revolving credit	(1,689,400)	-	-	-	(1,689,400)
Proceeds from issuance of term loan, net of discount	198,100	-	-	-	198,100
Proceeds from other long-term debt	-	-	750	-	750
Repayment of term loan	(13,527)	-	-	-	(13,527)
Repayment of other long-term debt	-	-	(1,104)	-	(1,104)
Payment of deferred financing costs	(522)	-	-	-	(522)
Payment of dividend for Mandatory Redeemable Preferred Stock	(11,514)	-	-	-	(11,514)
Dividends paid	(40,738)	-	-	-	(40,738)
Contributions made by noncontrolling interests	-	-	14,514	-	14,514
Distributions to noncontrolling interests	-	-	(45,985)	-	(45,985)
Purchase of noncontrolling interests	-	-	(1,000)	-	(1,000)
Payroll tax payments for equity awards issuance	-	(3,166)	-	-	(3,166)
Net change in intercompany accounts	(85,069)	89,135	(4,066)	-	-
Net cash provided by (used in) financing activities	630	85,969	(36,891)	-	49,708
Change in cash and cash equivalents	-	7,535	30,768	-	38,303
Cash and cash equivalents at beginning of period	-	18,232	80,526	-	98,758
Cash and cash equivalents at end of period	\$ -	\$ 25,767	\$ 111,294	\$ -	\$ 137,061

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 23 – CONDENSED CONSOLIDATING FINANCIAL INFORMATION (Continued)

Condensed Consolidating Statement of Cash Flows (Continued)

(In thousands)	Year ended December 31, 2015				
	Parent company/ issuer	Guarantor subsidiaries	Non-guarantor subsidiaries	Consolidating and eliminating adjustments	Consolidated
Net cash provided by operating activities	\$ 21,963	\$ 84,605	\$ 69,682	\$ -	\$ 176,250
Cash flows from investing activities:					
Routine capital expenditures	-	(110,776)	(11,155)	-	(121,931)
Development capital expenditures	-	(19,931)	-	-	(19,931)
Acquisitions, net of cash acquired	-	(511,683)	(161,864)	-	(673,547)
Acquisition deposits	-	176,511	-	-	176,511
Sale of assets	-	8,735	-	-	8,735
Proceeds from senior unsecured notes offering held in escrow	-	-	1,350,000	-	1,350,000
Interest in escrow for senior unsecured notes	-	-	23,438	-	23,438
Purchase of insurance subsidiary investments	-	-	(85,222)	-	(85,222)
Sale of insurance subsidiary investments	-	-	75,075	-	75,075
Net change in insurance subsidiary cash and cash equivalents	-	-	(12,271)	-	(12,271)
Proceeds from note receivable	-	25,000	-	-	25,000
Net change in other investments	-	(4,620)	-	-	(4,620)
Other	-	10,972	-	-	10,972
Net cash provided by (used in) investing activities	-	(425,792)	1,178,001	-	752,209
Cash flows from financing activities:					
Proceeds from borrowings under revolving credit	1,740,450	-	-	-	1,740,450
Repayment of borrowings under revolving credit	(1,631,850)	-	-	-	(1,631,850)
Proceeds from issuance of senior unsecured notes due 2020 and 2023	1,350,000	-	(1,350,000)	-	-
Proceeds from issuance of term loan, net of discount	199,000	-	-	-	199,000
Repayment of Gentiva debt	-	(1,177,363)	-	-	(1,177,363)
Repayment of term loan	(12,010)	-	-	-	(12,010)
Repayment of other long-term debt	-	-	(6,752)	-	(6,752)
Payment of deferred financing costs	(3,446)	-	-	-	(3,446)
Issuance of Common Stock in connection with employee benefit plans	534	-	-	-	534
Payment of costs associated with issuance of common stock and tangible equity units	(915)	-	-	-	(915)
Payment of dividend for Mandatory Redeemable Preferred Stock	(10,887)	-	-	-	(10,887)
Dividends paid	(40,119)	-	-	-	(40,119)
Contributions made by noncontrolling interests	-	-	2,152	-	2,152
Distributions to noncontrolling interests	-	-	(42,458)	-	(42,458)
Change in intercompany accounts	(1,612,720)	1,417,599	195,121	-	-
Payroll tax payments for equity awards issuance	-	(10,225)	-	-	(10,225)
Net cash provided by (used in) financing activities	(21,963)	230,011	(1,201,937)	-	(993,889)
Change in cash and cash equivalents	-	(111,176)	45,746	-	(65,430)
Cash and cash equivalents at beginning of period	-	129,408	34,780	-	164,188
Cash and cash equivalents at end of period	\$ -	\$ 18,232	\$ 80,526	\$ -	\$ 98,758

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 24 – LEGAL AND REGULATORY PROCEEDINGS

The Company provides services in a highly regulated industry and is subject to various legal actions and regulatory and other governmental and internal audits and investigations in the ordinary course of business (including investigations resulting from the Company's obligation to self-report suspected violations of law). These matters could (1) require the Company to pay substantial damages, fines, penalties or amounts in judgments or settlements, which individually or in the aggregate could exceed amounts, if any, that may be recovered under the Company's insurance policies where coverage applies and is available; (2) cause the Company to incur substantial expenses; (3) require significant time and attention from the Company's management; (4) subject the Company to sanctions, including possible exclusions from the Medicare and Medicaid programs; and (5) cause the Company to close or sell one or more facilities or otherwise modify the way the Company conducts business. The ultimate resolution of these matters, whether as a result of litigation or settlement, could have a material adverse effect on the Company's business, financial position, results of operations, and liquidity.

In accordance with authoritative accounting guidance related to loss contingencies, the Company records an accrued liability for litigation and regulatory matters that are both probable and reasonably estimable. Additional losses in excess of amounts accrued may be reasonably possible. The Company reviews loss contingencies that are reasonably possible and determines whether an estimate of the possible loss or range of loss, individually or in aggregate, can be disclosed in the Company's consolidated financial statements. These estimates are based upon currently available information for those legal and regulatory proceedings in which the Company is involved, taking into account the Company's best estimate of losses for those matters for which such estimate can be made. The Company's estimates involve significant judgment and a variety of assumptions, given that (1) these legal and regulatory proceedings may be in early stages; (2) discovery may not be completed; (3) damages sought in these legal and regulatory proceedings can be unsubstantiated or indeterminate; (4) the matters often involve legal uncertainties or evolving areas of law; (5) there are often significant facts in dispute; and/or (6) there is a wide range of possible outcomes. Accordingly, the Company's estimated loss or range of loss may change from time to time, and actual losses may be more or less than the current estimate. At this time, except as otherwise specifically noted, no estimate of the possible loss or range of loss, individually or in the aggregate, in excess of the amounts accrued, if any, can be made regarding the matters described below.

Set forth below are descriptions of the Company's significant legal proceedings.

Medicare and Medicaid payment reviews, audits, and investigations—As a result of the Company's participation in the Medicare and Medicaid programs, the Company faces and is currently subject to various governmental and internal reviews, audits, and investigations to verify the Company's compliance with these programs and applicable laws and regulations. The Company is routinely subject to audits under various government programs, such as the CMS Recovery Audit Contractor program, in which third party firms engaged by CMS conduct extensive reviews of claims data and medical and other records to identify potential improper payments to healthcare providers under the Medicare program. In addition, the Company, like other healthcare providers, is subject to ongoing investigations by the OIG, the DOJ and state attorneys general into the billing of services provided to Medicare and Medicaid patients, including whether such services were properly documented and billed, whether services provided were medically necessary, and general compliance with conditions of participation in the Medicare and Medicaid programs. Private pay sources such as third party insurance and managed care entities also often reserve the right to conduct audits. The Company's costs to respond to and defend any such reviews, audits, and investigations are significant and are likely to increase in the current enforcement environment. These audits and investigations may require the Company to refund or retroactively adjust amounts that have been paid under the relevant government program or by other payors. Further, an adverse review, audit, or investigation also could result in other adverse consequences, particularly if the underlying conduct is found to be pervasive or systemic. These consequences include (1) state or federal agencies imposing fines, penalties, and other sanctions on the Company; (2) loss of the Company's right to participate in the Medicare or Medicaid programs or one or more third party payor networks; (3) indemnity claims asserted by customers and others for which the Company provides services; and (4) damage to the Company's reputation in various markets, which could adversely affect the Company's ability to attract patients, customers and employees.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 24 – LEGAL AND REGULATORY PROCEEDINGS (Continued)

On January 12, 2016, the Company entered into a settlement agreement (the “Settlement Agreement”) with the United States of America, acting through the DOJ and on behalf of the OIG (the “United States”), to resolve the pending DOJ investigation concerning the operations of RehabCare, a therapy services company the Company acquired on June 1, 2011. Under the Settlement Agreement, the Company paid \$125 million, plus accrued interest from August 31, 2015, at the rate of 1.875% per annum to the United States during the first quarter of 2016. In the first quarter of 2015, the Company recorded a \$95 million loss reserve for this matter and disclosed an estimated settlement range of \$95 million to \$125 million. Based on the progress of continuing settlement discussions through October 2015, the Company recorded an additional \$30 million loss provision in the third quarter of 2015. The Company recorded an additional loss reserve of approximately \$2 million in the fourth quarter of 2015 related to the Settlement Agreement and associated costs and, in connection with establishing the final terms of the Settlement Agreement, also recorded an income tax benefit of \$47 million in the fourth quarter of 2015. In connection with the resolution of this matter, and in exchange for the OIG’s agreement not to exclude the Company or its subsidiaries from participating in the federal healthcare programs, on January 11, 2016, the Company entered into the RehabCare CIA.

In connection with the Settlement Agreement, RehabCare has received requests for indemnification from some of its current and former customers related to alleged damages stemming from payments made by these customers to the DOJ and the related legal and other costs. The Company settled indemnification disputes totaling \$5.8 million during 2017.

Whistleblower lawsuits—The Company is also subject to *qui tam* or “whistleblower” lawsuits under the federal False Claims Act and comparable state laws for allegedly submitting fraudulent bills for services to the Medicare and Medicaid programs. These lawsuits can result in monetary damages, fines, attorneys’ fees, and the award of bounties to private *qui tam* plaintiffs who successfully bring these lawsuits and to the respective government programs. The Company also could be subject to civil penalties (including the loss of the Company’s licenses to operate one or more facilities or healthcare activities), criminal penalties (for violations of certain laws and regulations), and exclusion of one or more facilities or healthcare activities from participation in the Medicare, Medicaid, and other federal and state healthcare programs. The lawsuits are in various stages of adjudication or investigation and involve a wide variety of claims and potential outcomes.

Employment-related lawsuits—The Company’s operations are subject to a variety of federal and state employment-related laws and regulations, including but not limited to the U.S. Fair Labor Standards Act, Equal Employment Opportunity laws, and enforcement policies of the Equal Employment Opportunity Commission, the Office of Civil Rights and state attorneys general, federal and state wage and hour laws, and a variety of laws enacted by the federal and state governments that govern these and other employment-related matters. Accordingly, the Company is currently subject to employee-related claims, class actions and other lawsuits and proceedings in connection with the Company’s operations, including but not limited to those related to alleged wrongful discharge, illegal discrimination, and violations of equal employment and federal and state wage and hour laws. Because labor represents such a large portion of the Company’s operating costs, noncompliance with these evolving federal and state laws and regulations could subject the Company to significant back pay awards, fines, and additional lawsuits and proceedings. These claims, lawsuits, and proceedings are in various stages of adjudication or investigation and involve a wide variety of claims and potential outcomes.

A purported wage and hour class action lawsuit is currently pending against the Company in federal district court for the Northern District of California. This lawsuit pertains to alleged errors made by the Company with respect to minimum wage and overtime payments resulting from a piece-rate payment system. The Company tentatively settled this lawsuit in December 2017 for \$12 million, subject to final court approval. The Company is responsible for \$7.5 million of the tentative settlement amount, as well as legal expenses, with insurance funding the remaining \$4.5 million. In connection with this lawsuit, the Company recorded a \$2.0 million loss provision in the first quarter of 2017, an additional \$3.0 million loss provision in the third quarter of 2017, and an additional \$2.5 million in the fourth quarter of 2017, for a total loss reserve of \$7.5 million. The Company continues to deny the allegations made in this lawsuit and will defend this action and any related claims vigorously.

KINDRED HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 24 – LEGAL AND REGULATORY PROCEEDINGS (Continued)

Minimum staffing lawsuits—Various states in which the Company operates have established minimum staffing requirements or may establish minimum staffing requirements in the future. While the Company seeks to comply with all applicable staffing requirements, the regulations in this area are complex and the Company may experience compliance issues from time to time. Failure to comply with such minimum staffing requirements may result in one or more facilities failing to meet the conditions of participation under relevant federal and state healthcare programs and the imposition of significant fines, damages, or other sanctions.

Shareholder actions—The Company is also subject to lawsuits and other shareholder actions brought from time to time. A shareholder derivative action (the “Complaint”) was previously pending against certain of the Company’s current and former officers and directors in circuit court for Jefferson County, Kentucky. The Complaint also named the Company as a nominal defendant. The Complaint alleged that the named current and former officers and directors breached their respective duties of good faith, loyalty, and candor, and other general fiduciary duties owed to the Company and its shareholders by, among other things, failing to exercise reasonable and prudent supervision over the management, policies, and controls of the Company in order to detect practices that existed at RehabCare resulting in the Company having to enter into two separate settlement agreements with the DOJ. The Complaint was settled in January 2018 in exchange for the Company’s agreement to pay plaintiff \$950,000 in fees and expenses. The Company previously recorded a loss reserve of \$1.0 million in the third quarter of 2017 related to this matter. The Company continues to deny the allegations made in the Complaint.

Six purported class action complaints related to the Merger have been filed on behalf of putative classes of the Company’s public stockholders (the “Merger Complaints”). Four of these complaints were filed in the United States District Court for the District of Delaware: *Sehrgosha v. Kindred Healthcare, Inc., et al.*, filed on February 8, 2018; *Carter v. Kindred Healthcare, Inc., et al.*, filed on February 14, 2018; *Rosenfeld v. Kindred Healthcare, Inc., et al.*, filed on February 15, 2018; and *Einhorn v. Kindred Healthcare, Inc., et al.*, filed on February 21, 2018. The remaining two complaints were filed in the United States District Court for the Western District of Kentucky: *Tompkins v. Kindred Healthcare, Inc., et al.*, filed on February 9, 2018; and *Buskirk v. Kindred Healthcare, Inc., et al.*, filed on February 13, 2018. The Company and individual members of the Board are named as defendants in each of the actions. The *Tompkins* action also names as defendants TPG, WCAS, Humana, Parent, HospitalCo Parent and Merger Sub. The Merger Complaints generally allege that the defendants violated the Securities Exchange Act of 1934, as amended, by failing to disclose material information in the Company’s preliminary proxy statement filed on February 5, 2018. The Merger Complaints seek, among other things, injunctive relief prohibiting the stockholder vote to approve the Merger and unspecified compensatory damages and attorneys’ fees. The Company denies the allegations made in the Merger Complaints and will defend these actions and any related claims vigorously.

Ordinary course matters—In addition to the matters described above, the Company is subject to investigations, claims, and lawsuits in the ordinary course of business, including investigations resulting from the Company’s obligation to self-report suspected violations of law and professional liability claims, particularly in the Company’s hospital and nursing center operations. In many of these claims, plaintiffs’ attorneys are seeking significant fines and compensatory and punitive damages in addition to attorneys’ fees. The Company maintains professional and general liability insurance in amounts and coverage that management believes are sufficient for the Company’s operations. However, the Company’s insurance may not cover all claims against the Company or the full extent of its liability.

KINDRED HEALTHCARE, INC.
QUARTERLY CONSOLIDATED FINANCIAL INFORMATION (UNAUDITED)
(In thousands, except per share amounts)

The following table represents summary quarterly consolidated financial information (unaudited) for the years ended December 31, 2017 and 2016:

	2017 (a)			
	First	Second	Third	Fourth
Revenues	\$ 1,539,490	\$ 1,535,831	\$ 1,477,820	\$ 1,480,982
Net income (loss):				
Income (loss) from continuing operations	10,323	(104,395)	(17,710)	(135,419)
Discontinued operations, net of income taxes:				
Income (loss) from operations	5,059	5,061	(14,291)	(12,683)
Loss on divestiture of operations	(6,166)	(294,039)	(49,663)	(29,392)
Loss from discontinued operations	(1,107)	(288,978)	(63,954)	(42,075)
Net income (loss)	9,216	(393,373)	(81,664)	(177,494)
Earnings attributable to noncontrolling interests:				
Continuing operations	(10,483)	(10,791)	(10,960)	(9,942)
Discontinued operations	(4,481)	(4,954)	(3,162)	(264)
	(14,964)	(15,745)	(14,122)	(10,206)
Loss attributable to Kindred	(5,748)	(409,118)	(95,786)	(187,700)
Earnings (loss) per common share:				
Basic:				
Income (loss) from continuing operations	-	(1.32)	(0.32)	(1.65)
Discontinued operations:				
Income (loss) from operations	-	-	(0.20)	(0.15)
Loss on divestiture of operations	(0.07)	(3.36)	(0.57)	(0.33)
Loss from discontinued operations	(0.07)	(3.36)	(0.77)	(0.48)
Net loss	(0.07)	(4.68)	(1.09)	(2.13)
Diluted:				
Income (loss) from continuing operations	-	(1.32)	(0.32)	(1.65)
Discontinued operations:				
Income (loss) from operations	-	-	(0.20)	(0.15)
Loss on divestiture of operations	(0.07)	(3.36)	(0.57)	(0.33)
Loss from discontinued operations	(0.07)	(3.36)	(0.77)	(0.48)
Net loss	(0.07)	(4.68)	(1.09)	(2.13)
Shares used in computing earnings (loss) per common share:				
Basic	87,085	87,506	87,597	87,902
Diluted	87,085	87,506	87,597	87,902
Market prices:				
High	9.90	11.75	11.90	10.15
Low	6.58	7.60	5.50	5.75

- (a) See Note 5 for a discussion of impairment charges, Note 6 for a discussion of loss on divestiture of discontinued operations and Note 11 for a discussion on deferred tax asset valuation allowances and deferred tax liability adjustments.

KINDRED HEALTHCARE, INC.
QUARTERLY CONSOLIDATED FINANCIAL INFORMATION (UNAUDITED) (Continued)
(In thousands, except per share amounts)

	2016 (a)			
	First	Second	Third	Fourth
Revenues	\$ 1,604,214	\$ 1,609,169	\$ 1,564,060	\$ 1,515,086
Net income (loss):				
Income (loss) from continuing operations	21,980	30,227	(648,015)	(1,880)
Discontinued operations, net of income taxes:				
Income (loss) from operations	3,275	7,170	(23,292)	6,655
Gain (loss) on divestiture of operations	262	(83)	-	(6,923)
Income (loss) from discontinued operations	3,537	7,087	(23,292)	(268)
Net income (loss)	25,517	37,314	(671,307)	(2,148)
Earnings attributable to noncontrolling interests:				
Continuing operations	(7,851)	(8,847)	(9,574)	(8,575)
Discontinued operations	(4,665)	(4,678)	(4,732)	(4,684)
	(12,516)	(13,525)	(14,306)	(13,259)
Income (loss) attributable to Kindred	13,001	23,789	(685,613)	(15,407)
Earnings (loss) per common share:				
Basic:				
Income (loss) from continuing operations	0.16	0.24	(7.57)	(0.12)
Discontinued operations:				
Income (loss) from operations	(0.01)	0.03	(0.32)	0.02
Gain (loss) on divestiture of operations	-	-	-	(0.08)
Income (loss) from discontinued operations	(0.01)	0.03	(0.32)	(0.06)
Net income (loss)	0.15	0.27	(7.89)	(0.18)
Diluted:				
Income (loss) from continuing operations	0.16	0.23	(7.57)	(0.12)
Discontinued operations:				
Income (loss) from operations	(0.01)	0.03	(0.32)	0.02
Gain (loss) on divestiture of operations	-	-	-	(0.08)
Income (loss) from discontinued operations	(0.01)	0.03	(0.32)	(0.06)
Net income (loss)	0.15	0.26	(7.89)	(0.18)
Shares used in computing earnings (loss) per common share:				
Basic	86,590	86,836	86,869	86,904
Diluted	87,249	87,500	86,869	86,904
Market prices:				
High	12.65	15.66	12.55	10.69
Low	7.96	10.43	9.67	5.65

(a) See Note 5 for a discussion of impairment charges and Note 11 for a discussion on deferred tax asset valuation allowances.

KINDRED HEALTHCARE, INC.
SCHEDULE II — VALUATION AND QUALIFYING ACCOUNTS
FOR THE YEARS ENDED DECEMBER 31, 2017, 2016 AND 2015
(In thousands)

	Balance at beginning of period	Additions			Deductions or payments	Balance at end of period
		Charged to cost and expenses	Other	Acquisitions		
Allowance for loss on accounts receivable:						
Year ended December 31, 2015	\$ 52,855	\$ 52,460	\$ -	\$ -	\$ (42,419)	\$ 62,896
Year ended December 31, 2016	62,896	40,804	-	-	(32,630)	71,070
Year ended December 31, 2017	71,070	68,284	-	-	(42,455)	96,899
Allowance for deferred taxes (a):						
Year ended December 31, 2015	\$ 50,969	\$ -	\$ -	\$ 10,063	\$ (14,356)	\$ 46,676
Year ended December 31, 2016	46,676	385,752	-	(86)	(9,188)	423,154
Year ended December 31, 2017	423,154	115,921	-	-	(160,243)	378,832

- (a) The Company identified deferred income tax assets for federal income tax NOLs of \$162.2 million (tax effected at 21%), \$162.4 million (tax effected at 35%) and \$119.1 million (tax effected at 35%) at December 31, 2017, December 31, 2016 and December 31, 2015, respectively, with corresponding federal deferred income tax valuation allowances of \$162.2 million and \$162.4 million at December 31, 2017 and December 31, 2016, respectively, after determining that these federal net deferred income tax assets were not realizable. There was no corresponding federal deferred income tax valuation allowances at December 31, 2015. The Company had deferred income tax assets for state income tax NOLs of \$82.2 million, \$60.4 million and \$60.0 million at December 31, 2017, December 31, 2016 and December 31, 2015, respectively, and corresponding state deferred income tax valuation allowances of \$82.0 million, \$60.0 million and \$46.7 million at December 31, 2017, December 31, 2016 and December 31, 2015, respectively, after determining that all or a portion of these state net deferred income tax assets were not realizable. See Note 11 for further discussions related to the deferred tax asset valuation allowance and deferred tax liabilities.

AMENDMENT NO. 1 TO SECOND AMENDED AND RESTATED MASTER LEASE AGREEMENT NO. 5

THIS AMENDMENT NO. 1 TO SECOND AMENDED AND RESTATED MASTER LEASE AGREEMENT NO. 5 (hereinafter, this “**Amendment**”) is executed, and effective, as of November 7, 2017 (the “**Amendment Effective Date**”) and is by and among VENTAS REALTY, LIMITED PARTNERSHIP, a Delaware limited partnership (together with its successors and assigns, “**Lessor**”), and KINDRED HEALTHCARE, INC., a Delaware corporation formerly known as Vencor, Inc. (“**Kindred**”), and KINDRED HEALTHCARE OPERATING, INC., a Delaware corporation formerly known as Vencor Operating, Inc. (“**Operator**”; Operator, jointly and severally with Kindred and permitted successors and assignees of Operator and Kindred, “**Tenant**”).

RECITALS

A. Lessor and Tenant have heretofore entered into that certain Second Amended and Restated Master Lease Agreement No. 5 (such agreement, as heretofore amended, is herein referred to as “**ML5**”) dated as of November 11, 2016, and Ventas, Inc. executed a Joinder to such ML5 with respect to Facility No. 4614 (each capitalized term that is used in this Amendment and not otherwise defined shall have the same meaning herein as in ML5).

B. Lessor and Tenant desire to amend ML5 on the terms described in this Amendment.

NOW, THEREFORE, in consideration of the foregoing, and of other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Lessor and Tenant hereby agree as follows:

1. **Kindred Hospital- Kansas City**. Contemporaneously with the Amendment Effective Date, the Leased Property commonly known as Kindred Hospital- Kansas City (Facility #4612) has been sold by Lessor to Tenant or its affiliate. Lessor and Tenant agree that, simultaneously with such sale, ML5 is, and shall be, terminated as it applies to such Leased Property in accordance with the terms of Section 40.16 and the other provisions of ML5, except that (a) as set forth in Section 2 below (and without limitation of the provisions of such Section 2 that implement a Base Rent increase as of the Amendment Effective Date), (i) the Base Rent under ML5 shall not be reduced on account of such sale and (ii) the Base Rent that was attributable to such Leased Property has been, and shall be, reallocated among the other Leased Properties that remain demised under ML5, (b) in the event of any conflict between the terms of ML5 and the terms of this Amendment, the terms of this Amendment shall govern and control, and (c) in the event of any conflict between the terms of this Section 1 and the terms of Section 2 below, the terms of Section 2 below shall govern and control.

2. **Base Rent and Other Definitions; Exhibit C.** Lessor and Tenant hereby agree to amend ML5 as follows, effective as of the Amendment Effective Date:

2.1. In consideration of the parties' entry into this Amendment, Lessor and Tenant have agreed to revise and reset the Base Rent owing under ML5 by (a) contrary to Section 40.16 of ML5, not decreasing the Base Rent under ML5 on account of the sale referenced in Section 1 above, (b) increasing such Base Rent by \$119,744.04 per annum to \$124,270,833.00 per annum, effective as of the Amendment Effective Date, and (c) amending and restating in its entirety the definition of "Base Rent" contained in Section 2.1 of ML5 to read as follows:

"Base Rent": (i) For any period ending prior to the First Amendment Effective Date, rent at the aggregate annual rate applicable under this Lease, as in effect from time to time prior to its amendment pursuant to the First Amendment, (ii) for the period from the First Amendment Effective Date through April 30, 2018, rent at an annual rate equal to One Hundred Twenty-Four Million Two Hundred Seventy Thousand Eight Hundred Thirty-Three Dollars (\$124,270,833.00) per annum, and (iii) for a particular Rent Calculation Year thereafter, an annual rental amount equal to the sum of:

(a) Number 1 and 4 Portfolio:

(i) intentionally omitted; and

(ii) for each Rent Calculation Year commencing on or after May 1, 2018, (A) the Prior Period Number 1 and 4 Portfolio Base Rent, **plus** (B) the sum of (x)(1) if the CPI Increase, expressed as a percentage, applicable to such Rent Calculation Year is 0.00% or less, zero, (2) if the product of three (3) times the CPI Increase, expressed as a percentage, applicable to such Rent Calculation Year, is greater than 4.00%, the product of 4% times the portion of the Prior Period Number 1 and 4 Portfolio Base Rent that is allocated to Leased Properties that have as their Primary Intended Use use as a nursing center ("SNF Leased Properties"), and (3) in all other cases, the product of three (3) times the CPI Increase, expressed as a percentage, applicable to such Rent Calculation Year times the portion of the Prior Period Number 1 and 4 Portfolio Base Rent that is allocated to SNF Leased Properties, **plus** (y) if the Patient Revenues relative to the Hospital Leased Properties (as defined below) within the Number 1 and 4 Portfolio for the calendar year preceding the commencement of such Rent Calculation Year equaled or exceeded seventy-five percent (75%) of the Adjusted Base Patient Revenues relative to such Leased Properties, the product of two and seven-tenths percent (2.7%) times the portion of the Prior Period Number 1 and 4 Portfolio Base Rent that is allocated to Leased Properties that have as their Primary Intended Use use as a hospital ("Hospital Leased Properties")

(the amount described in this subsection (a) with respect to a particular Rent Calculation Year is herein referred to as the "Number 1 and 4 Portfolio Base Rent Component"); **plus**

(b) Number 2 Portfolio:

(i) intentionally omitted; and

(ii) for each Rent Calculation Year commencing on or after May 1, 2018, (A) the Prior Period Number 2 Portfolio Base Rent, **plus** (B) the sum of (x)(1) if the CPI Increase, expressed as a percentage, applicable to such Rent Calculation Year is 0.00% or less, zero, (2) if the product of three (3) times the CPI Increase, expressed as a percentage, applicable to such Rent Calculation Year, is greater than 4.00%, the product of 4% times the portion of the Prior Period Number 2 Portfolio Base Rent that is allocated to SNF Leased Properties, and (3) in all other cases, the product of three (3) times the CPI Increase, expressed as a percentage, applicable to such Rent Calculation Year times the portion of the Prior Period Number 2 Portfolio Base Rent that is allocated to SNF Leased Properties, **plus** (y) if the Patient Revenues relative to Hospital Leased Properties within the Number 2 Portfolio for the calendar year preceding the commencement of such Rent Calculation Year equaled or exceeded seventy-five percent (75%) of the Adjusted Base Patient Revenues relative to such Leased Properties, the product of (1) the portion of the Prior Period Number 2 Portfolio Base Rent that is allocated to Hospital Leased Properties times (2)(x) two and twenty-five hundredths percent (2.25%), if the CPI Increase, expressed as a percentage, applicable to such Rent Calculation Year is less than 2.25%, (y) four percent (4%), if the CPI Increase, expressed as a percentage, applicable to such Rent Calculation Year is greater than 4%, or (z) the CPI Increase, expressed as a percentage, applicable to such Rent Calculation Year, in all other cases

(the amount described in this subsection (b) with respect to a particular Rent Calculation Year is herein referred to as the "Number 2 Portfolio Base Rent Component"); **plus**

(c) Number 5 Portfolio:

for each Rent Calculation Year, (i) the Prior Period Number 5 Portfolio Base Rent, **plus** (ii)(A) if the CPI Increase, expressed as a percentage, applicable to such Rent Calculation Year is 0.00% or less, zero, (B) if the CPI Increase, expressed as a percentage, applicable to such Rent Calculation Year, is greater than 4.00%, the product of 4% times the Prior Period Number 5 Portfolio Base Rent, and (C) in all other cases, the product of the CPI Increase, expressed as a percentage, applicable to such Rent Calculation Year times the Prior Period Number 5 Portfolio Base Rent

(the amount described in this subsection (c) with respect to a particular Rent Calculation Year is herein referred to as the "Number 5 Portfolio Base Rent Component").

Notwithstanding the foregoing, (I) nothing contained in this definition shall limit the applicability of Section 19.2 and Section 19.3 hereof and (II) the Base Rent amounts referenced above are subject to adjustment as expressly provided in other provisions of this Lease (e.g., due to the termination of this Lease as it relates to Leased Property(ies) due to a casualty, condemnation or an Event of Default, due to a combination of this Lease with another Lease pursuant to Section 40.16 hereof, due to the transfer of Leased

Properties demised under ML1, ML2 and/or ML4 into this Lease as provided in the ML1/2/4 Amendments, ARML No. 3 and Section 1.4 of this Lease or due to a sale of a Leased Property and the termination of this Lease on account thereof as contemplated in ARML No. 3).

2.2. The following new definitions are hereby added to Section 2.1 of ML5:

“First Amendment”: That certain Amendment No. 1 to Second Amended and Restated Master Lease Agreement No. 5 dated effective as of the First Amendment Effective Date between Lessor and Tenant.

“First Amendment Effective Date”: November 7, 2017.

2.3. Effective as of the Amendment Effective Date, Exhibit C to ML5 is amended and restated in its entirety to read as set forth in **Attachment 1** attached to and made a part of this Amendment.

3. Certain Lessor Costs. Tenant shall pay, as Additional Charges, on behalf of Lessor, or reimburse Lessor for, any and all actual, reasonable, and documented third party out-of-pocket costs or expenses paid or incurred by Lessor, including, without limitation, reasonable attorneys’ fees, in connection with the negotiation, execution and delivery of this Amendment.

4. Conflict; Unified Commercial Operating Lease. In the event of a conflict between ML5 and this Amendment, this Amendment shall control in all events. Except as set forth in this Amendment, ML5 shall remain in full force and effect. It is acknowledged and agreed that, except as otherwise expressly provided herein or in ML5, the inclusion of each of the Leased Properties on a continuing basis in ML5 is an essential element of the leasing transaction described in ML5 for Lessor, and that, except as otherwise expressly provided herein or in ML5, Lessor shall not be obligated and may not be required to lease to Tenant less than all of the Leased Properties demised pursuant to ML5. It is further acknowledged and agreed that ML5 is not a residential lease within the meaning of the U.S. Bankruptcy Code, as amended, and that ML5 is an operating lease, and not a capital lease, for all accounting, tax and legal purposes.

5. Counterparts; Facsimile. This Amendment may be executed in one or more counterparts, and signature pages may be delivered by facsimile or electronic mail, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

6. Integration. This Amendment and ML5 contain the entire agreement between Lessor and Tenant with respect to the subject matter hereof. No representations, warranties or agreements have been made by Lessor or Tenant except as set forth in this Amendment and ML5.

7. Severability. If any term or provision of this Amendment is to be invalid or unenforceable, such term or provision shall be modified as slightly as possible so as to render it valid and enforceable; if such term or provision, as modified, shall be held or deemed invalid or unenforceable, such holding shall not affect the remainder of this Amendment and same shall remain in full force and effect.

8. **Subject to Law.** This Amendment was negotiated in the State of New York, which State the parties agree has a substantial relationship to the parties and to the underlying transaction embodied hereby. In all respects, the law of the State of New York shall govern the validity of and enforceability of the obligations of the parties set forth herein, but the parties hereto will submit to jurisdiction and the laying of venue for any suit on this Amendment in the Commonwealth of Kentucky.

9. **Waivers.** No waiver of any condition or covenant herein contained, or of any breach of any such condition or covenant, shall be held or taken to be a waiver of any subsequent breach of such covenant or condition, or to permit or excuse its continuance or any future breach thereof or of any condition or covenant herein.

10. **Binding Character.** This Amendment shall be binding upon and shall inure to the benefit of the heirs, successors, personal representatives, and permitted assigns of Lessor and Tenant.

11. **Modification.** This Amendment may be only be modified by a writing signed by both Lessor and Tenant.

12. **Forbearance.** No delay or omission by any party hereto to exercise any right or power accruing upon any noncompliance or default by any other party hereto with respect to any of the terms hereof shall impair any such right or power or be construed to be a waiver thereof.

13. **Headings and Captions.** The headings and captions of the sections of this Amendment are for convenience of reference only and shall not affect the meaning or interpretation of this Amendment or any provision hereof.

14. **Gender and Number.** As used in this Amendment, the neuter shall include the feminine and masculine, the singular shall include the plural, and the plural shall include the singular, except where expressly provided to the contrary.

15. **Coordinated Disclosures.** The parties hereto shall cooperate with respect to any disclosures of information concerning this Amendment and the transactions contemporaneous herewith, and shall share such disclosures with the other parties a reasonable period of time prior to making such disclosures in order to facilitate such cooperation.

16. **Authority.** The parties represent and warrant to each other that each of them, respectively, has full power, right and authority to execute and perform this Amendment and all corporate action necessary to do so has been duly taken. In order to induce Lessor to enter into this Amendment, Tenant hereby represents and warrants to Lessor that Tenant's entry into this Amendment does not require that any consent or approval first be obtained from any lender of Tenant or its Affiliates.

[Signature Pages Follow]

IN WITNESS WHEREOF, the parties hereto have executed this Amendment as of the day and year first above written.

TENANT:

KINDRED HEALTHCARE, INC., a Delaware corporation formerly known as Vencor, Inc.

By: /s/ Cristina E. O'Brien
Cristina E. O'Brien,
Vice President, Real Estate Counsel

TENANT:

KINDRED HEALTHCARE OPERATING, INC., a Delaware corporation formerly known as Vencor Operating, Inc.

By: /s/ Cristina E. O'Brien
Cristina E. O'Brien,
Vice President, Real Estate Counsel

LESSOR:

VENTAS REALTY, LIMITED PARTNERSHIP, a Delaware limited partnership

By: Ventas, Inc., a Delaware corporation, its general partner

By: /s/ Nicholas W. Jacoby
Nicholas W. Jacoby,
Senior Vice President

JOINDER

The undersigned, VENTAS, INC., a Delaware corporation, hereby joins in the foregoing Amendment No. 1 to ML5 solely for the purpose of, subject to Section 40.2 of ML5, joining with Ventas Realty, Limited Partnership, on a joint and several basis, as Lessor under ML5, as amended by the foregoing amendment, with respect to, and only with respect to, the Leased Property commonly known as Kindred Hospital – Philadelphia (Facility No. 4614), and for no other purposes. Notwithstanding anything to the contrary contained in ML5, as amended by the foregoing amendment, Tenant acknowledges and agrees, by the acceptance of this Joinder, that Ventas, Inc. shall have no liability or obligations under ML5, as amended by the foregoing amendment, as lessor or otherwise, with respect to any Leased Property other than the aforesaid Kindred Hospital - Philadelphia Leased Property.

VENTAS, INC.

By: /s/ Nicholas W. Jacoby
Nicholas W. Jacoby,
Senior Vice President

ATTACHMENT 1

Exhibit C

Allocation Schedule – Applicable Transferred Property Percentages

		<u>Master Lease Agreement No. 5</u>		
	Facility ID	Name	Base Rent as of First Amendment Effective Date	Transferred Property Percentage as of First Amendment Effective Date
4	198	Harrington House Nursing and Rehabilitation Center	1,318,540.92	1.06102%
6	559	Birchwood Terrace Healthcare	1,113,666.12	0.89616%
7	573	Eagle Pond Rehabilitation and Living Center	1,286,776.56	1.03546%
12	4602	Kindred Hospital - South Florida - Coral Gables	3,327,797.00	2.67786%
13	4628	Kindred Hospital - Chattanooga	2,783,567.64	2.23992%
14	4637	Kindred Hospital - Chicago (North Campus)	8,841,795.84	7.11494%
15	4652	Kindred Hospital - North Florida	3,281,233.32	2.64039%
16	4680	Kindred Hospital - St. Louis	1,343,978.64	1.08149%
17	4690	Kindred Hospital - Chicago (Northlake Campus)	4,489,726.44	3.61286%
18	4653	Kindred Hospital - Tarrant County (Fort Worth Southwest)	5,744,693.84	4.62272%
20	4674	Kindred Hospital - Central Tampa	4,634,593.56	3.72943%
21	4635	Kindred Hospital - San Antonio	2,308,827.60	1.85790%
22	4647	Kindred Hospital - Las Vegas (Sahara)	2,750,956.92	2.21368%
23	4660	Kindred Hospital - Mansfield	1,377,411.00	1.10839%
24	4662	Kindred Hospital - Greensboro	2,713,030.80	2.18316%
25	4614	Kindred Hospital - Philadelphia	2,366,505.48	1.90431%
26	4664	Kindred Hospital - Albuquerque	4,806,005.70	3.86736%

27	4665	Kindred Hospital - Denver	1,730,471.64	1.39250%
28	4871	Kindred Hospital - Chicago - Lakeshore	3,124,443.72	2.51422%
29	4611	Kindred Hospital - Bay Area St. Petersburg	4,259,805.48	3.42784%
30	4633	Kindred Hospital - Louisville	8,604,430.44	6.92393%
31	4638	Kindred Hospital - Indianapolis	2,287,966.56	1.84111%
32	4644	Kindred Hospital - Brea	4,702,299.12	3.78391%
33	4822	Kindred Hospital - San Francisco Bay Area	5,596,501.92	4.50347%
34	4876	Kindred Hospital - South Florida - Hollywood	3,935,722.20	3.16705%
35	4842	Kindred Hospital - Westminster	8,466,685.20	6.81309%
36	4848	Kindred Hospital - San Diego	2,998,841.76	2.41315%
38	4615	Kindred Hospital - Sycamore	3,619,077.60	2.91225%
39	4654	Kindred Hospital (Houston Northwest)	3,232,485.36	2.60116%
40	4807	Kindred Hospital - Ontario	9,937,988.05	7.99706%
41	4645	Kindred Hospital - South Florida Ft. Lauderdale	2,580,093.36	2.07619%
42	4685	Kindred Hospital - Houston	4,704,913.21	3.78602%
Total			\$124,270,833.00	100.00000%

REGISTRANT'S SUBSIDIARIES

December 31, 2017

Comerstone Insurance Company, a Cayman Islands corporation

Kindred Healthcare Operating, Inc., a Delaware corporation

Kindred THC Chicago, LLC an Illinois limited liability company

KHOI New, LLC, a Delaware limited liability company

Kindred Development 27, L.L.C., a Delaware limited liability company

Kindred Hospitals East, L.L.C., a Delaware limited liability company

Goddard Nursing, L.L.C., a Delaware limited liability company

Kindred Braintree Hospital, L.L.C., a Delaware limited liability company

Kindred Hospital Palm Beach, L.L.C., a Delaware limited liability company

Kindred Hospital-Pittsburgh-North Shore, L.L.C., a Delaware limited liability company

Kindred Development 17, L.L.C., a Delaware limited liability company

Springfield Park View Hospital, L.L.C., a Delaware limited liability company

Kindred Hospitals West, L.L.C., a Delaware limited liability company

Kindred Nursing Centers East, L.L.C., a Delaware limited liability company

Avery Manor Nursing, L.L.C., a Delaware limited liability company

Braintree Nursing, L.L.C., a Delaware limited liability company

Country Estates Nursing, L.L.C., a Delaware limited liability company

Forestview Nursing, L.L.C., a Delaware limited liability company

Greens Nursing and Assisted Living, L.L.C., a Delaware limited liability company

Harborlights Nursing, L.L.C., a Delaware limited liability company

Highgate Nursing, L.L.C., a Delaware limited liability company

Highlander Nursing, L.L.C., a Delaware limited liability company

Kindred Development Holdings 3, L.L.C., a Delaware limited liability company

Kindred Development Holdings 5, L.L.C., a Delaware limited liability company

Kindred Development 7, L.L.C., a Delaware limited liability company

Kindred Development 8, L.L.C., a Delaware limited liability company

Physician Housecalls, LLC, a Colorado limited liability company

Kindred Development 9, L.L.C., a Delaware limited liability company

House Call Doctors, Inc., a Texas corporation

National House Call Practitioners, a Texas non-profit corporation

U.S. House Call Practitioners, Inc., a Texas corporation

Kindred Development 10, L.L.C., a Delaware limited liability company

Kindred Development 11, L.L.C., a Delaware limited liability company

Kindred Development 12, L.L.C., a Delaware limited liability company

Kindred Development 13, L.L.C., a Delaware limited liability company

Laurel Lake Health and Rehabilitation, L.L.C., a Delaware limited liability company

Massachusetts Assisted Living, L.L.C., a Delaware limited liability company

Meadows Nursing, L.L.C., a Delaware limited liability company

Tower Hill Nursing, L.L.C., a Delaware limited liability company

KNCE New, LLC, a Delaware limited liability company

Kindred Nursing Centers West, L.L.C., a Delaware limited liability company

Maine Assisted Living, L.L.C., a Delaware limited liability company

California Nursing Centers, L.L.C., a Delaware limited liability company

Bayberry Care Center, L.L.C., a Delaware limited liability company

Care Center of Rossmoor, L.L.C., a Delaware limited liability company

Greenbrae Care Center, L.L.C., a Delaware limited liability company

Medical Hill Rehab Center, L.L.C., a Delaware limited liability company

Pacific Coast Care Center, L.L.C., a Delaware limited liability company

Siena Care Center, L.L.C., a Delaware limited liability company

Smith Ranch Care Center, L.L.C., a Delaware limited liability company

Ygnacio Valley Care Center, L.L.C., a Delaware limited liability company

Kindred Nevada, L.L.C., a Delaware limited liability company

Kindred Systems, Inc., a Delaware corporation

Kindred Healthcare Services, Inc., a Delaware corporation

Lacuna Health, Inc., a Delaware corporation

Kindred Rehab Services, Inc., a Delaware corporation

 TherEx, Inc., a Delaware corporation

 The Therapy Group, Inc., a Louisiana corporation

Peoplefirst Virginia, L.L.C., a Delaware limited liability company

Kindred Hospice Services, L.L.C., a Delaware limited liability company

 Peoplefirst HomeCare & Hospice of Colorado, L.L.C., a Delaware limited liability company

 Peoplefirst HomeCare of Colorado, L.L.C., a Delaware limited liability company

 Peoplefirst HomeCare & Hospice of Indiana, L.L.C., a Delaware limited liability company

 Peoplefirst HomeCare & Hospice of Massachusetts, L.L.C., a Delaware limited liability company

 Peoplefirst HomeCare & Hospice of Ohio, L.L.C., a Delaware limited liability company

 PF Development 15, L.L.C., a Delaware limited liability company

PF Development 5, L.L.C., a Delaware limited liability company

PF Development 6, L.L.C., a Delaware limited liability company

PF Development 7, L.L.C., a Delaware limited liability company

PF Development 8, L.L.C., a Delaware limited liability company

PF Development 9, L.L.C., a Delaware limited liability company

 IntegraCare Holdings, Inc., a Delaware corporation

 Aberdeen Holdings, Inc., a Texas corporation

 IntegraCare Home Health Services, Inc., a Texas corporation

 IntegraCare of Texas, LLC, a Texas limited liability company

 GBA Holdings, Inc., a Texas corporation

 Focus Care Health Resources, Inc., a Texas corporation

 IntegraCare Intermediate Holdings, Inc., a Delaware corporation

 Able Home Healthcare, Inc., a Texas corporation

Compass Hospice, Inc., a Texas corporation
GBA West, LLC, a Texas limited liability company
IntegraCare of Olney Home Health, LLC, a Texas limited liability company
IntegraCare of Athens-Home Health, LLC, a Texas limited liability company
IntegraCare of Athens-Hospice, LLC, a Texas limited liability company
IntegraCare of Albany, LLC, a Texas limited liability company
IntegraCare of Granbury, LLC, a Texas limited liability company
Home Health of Rural Texas, Inc., a Texas corporation
Trinity Hospice of Texas, LLC, a Texas limited liability company
IntegraCare of Abilene, LLC, a Texas limited liability company
IntegraCare Hospice of Abilene, LLC, a Texas limited liability company
IntegraCare of Littlefield, LLC, a Texas limited liability company
IntegraCare of Wichita Falls, LLC, a Texas limited liability company
IntegraCare of West Texas Home Health, LLC, a Texas limited liability company
IntegraCare of West Texas-Hospice, LLC, a Texas limited liability company
Texas Health Management Group, LLC, a Texas limited liability company
Vernon Home Health Care Agency, LLC, a Texas limited liability company
Wellstream Health Services, LLC, a Texas limited liability company
West Texas, LLC, a Texas limited liability company
Outreach Health Services of the Panhandle, LLC, a Texas limited liability company
BWB Sunbelt Home Health Services, LLC, a Texas limited liability company
Outreach Health Services of North Texas, LLC, a Texas limited liability company

North West Texas Home Health Services, LLC, a Texas limited liability company

PF Development 10, L.L.C., a Delaware limited liability company

Professional Healthcare, LLC, a Delaware limited liability company

NP Plus, LLC, a Delaware limited liability company

Haven Health, LLC, a Delaware limited liability company

PHH Acquisition Corp., a Delaware corporation

Professional Healthcare at Home, LLC, a California limited liability company

HHS Healthcare Corp., a Delaware corporation

Home Health Services, Inc., a Utah corporation

Southern Utah Home Health, Inc., a Utah corporation

Southern Nevada Home Health Care, Inc., a Nevada corporation

Central Arizona Home Health Care, Inc., an Arizona corporation

KAH Development 16, Inc., a Utah corporation

PF Development 16, L.L.C., a Delaware limited liability company

PF Development 17, L.L.C., a Delaware limited liability company

PF Development 18, L.L.C., a Delaware limited liability company

PF Development 19, L.L.C., a Delaware limited liability company

DH/KND, L.L.C., a Delaware limited liability company

Community Home Health, L.L.C., a Delaware limited liability company

PF Development 20, L.L.C., a Delaware limited liability company

PF Development 21, L.L.C., a Delaware limited liability company

SHC Holding, Inc., a Delaware corporation

SHC Rehab, Inc., a Florida corporation

Senior Home Care, Inc., a Florida corporation

HomeCare Holdings, Inc., a Florida corporation

Med-Tech Services of Dade, Inc., a Florida corporation

Med-Tech Private Care, Inc., a Florida corporation

Advanced Oncology Services, Inc., a Florida corporation

Med. Tech. Services of South Florida, Inc., a Florida corporation

Med- Tech Services of Palm Beach, Inc., a Florida corporation

Synergy, Inc., a Louisiana corporation

Synergy Home Care – Capitol Region, Inc., a Louisiana corporation

Synergy Home Care – Northeastern Region, Inc., a Louisiana corporation

Synergy Home Care – Acadiana Region, Inc., a Louisiana corporation

Synergy Home Care – Southeastern Region, Inc., a Louisiana corporation

Synergy Home Care – Central Region, Inc., a Louisiana corporation

Synergy Home Care – Northwestern Region, Inc., a Louisiana corporation

Synergy Home Care – Northshore Region, Inc., a Louisiana corporation

Synergy Healthcare Group, Inc., a Louisiana corporation

PF Development 22, L.L.C., a Delaware limited liability company

Mills Medical Practices, LLC, an Ohio limited liability company

PF Development 23, L.L.C., a Delaware limited liability company

KAH Development 1, L.L.C., a Delaware limited liability company

KAH Development 2, L.L.C., a Delaware limited liability company

KAH Development 3, L.L.C., a Delaware limited liability company

Silver State ACO, LLC, a Nevada limited liability company

KAH Development 4, L.L.C., a Delaware limited liability company

KAH Development 5, L.L.C., a Delaware limited liability company

KAH Development 6, L.L.C., a Delaware limited liability company

KAH Development 7, L.L.C., a Delaware limited liability company

KAH Development 8, L.L.C., a Delaware limited liability company

KAH Development 9, L.L.C., a Delaware limited liability company

KAH Development 10, L.L.C., a Delaware limited liability company

KAH Development 11, L.L.C., a Delaware limited liability company

KAH Development 12, L.L.C., a Delaware limited liability company

KAH Development 13, L.L.C., a Delaware limited liability company

KAH Development 14, L.L.C., a Delaware limited liability company

KAH Development 15, L.L.C., a Delaware limited liability company

RehabCare Development 2, L.L.C., a Delaware limited liability company

East Valley Rehabilitation Hospital, L.L.C., a Delaware limited liability company

Dignity-Kindred Rehabilitation Hospital East Valley, L.L.C., a Delaware limited liability company

RehabCare Development 3, L.L.C., a Delaware limited liability company

RehabCare Development 4, L.L.C., a Delaware limited liability company

RehabCare Development 5, L.L.C., a Delaware limited liability company

KND Development 50, L.L.C., a Delaware limited liability company

KND Development 51, L.L.C., a Delaware limited liability company

KND Development 52, L.L.C., a Delaware limited liability company

KND Development 53, L.L.C., a Delaware limited liability company

KND Development 54, L.L.C., a Delaware limited liability company

KND Development 55, L.L.C., a Delaware limited liability company

KND Development 56, L.L.C., a Delaware limited liability company

Palomar / Kindred, LLC, a Delaware limited liability company

Palomar Long Term Acute Care Pavilion, LLC, a Delaware limited liability company

Palomar Health Rehabilitation Institute, LLC, a Delaware limited liability company

KND Development 57, L.L.C., a Delaware limited liability company

KND Development 59, L.L.C., a Delaware limited liability company

KND Development 62, L.L.C., a Delaware limited liability company

KND Development 63, L.L.C., a Delaware limited liability company

KND Real Estate Holdings, L.L.C., a Delaware limited liability company

KND Hospital Real Estate Holdings, L.L.C., a Delaware limited liability company

KND Real Estate 8, L.L.C., a Delaware limited liability company

KND Real Estate 9, L.L.C., a Delaware limited liability company

KND Real Estate 14, L.L.C., a Delaware limited liability company

KND Real Estate 20, L.L.C., a Delaware limited liability company

KND Real Estate 21, L.L.C., a Delaware limited liability company

KND Real Estate 22, L.L.C., a Delaware limited liability company

KND Real Estate 23, L.L.C., a Delaware limited liability company

KND Development 64, LLC, a Delaware limited liability company

KND Development 65, LLC, a Delaware limited liability company

KND Real Estate 26, L.L.C., a Delaware limited liability company

KND Development 66, LLC, a Delaware limited liability company

KND Development 67, LLC, a Delaware limited liability company

KND Real Estate 29, L.L.C., a Delaware limited liability company

KND Real Estate 30, L.L.C., a Delaware limited liability company

KND Development 68, LLC, a Delaware limited liability company

KND Real Estate 32, L.L.C., a Delaware limited liability company

KND Real Estate 46, L.L.C., a Delaware limited liability company

KND Development 69, LLC, a Delaware limited liability company

KND SNF Real Estate Holdings, L.L.C., a Delaware limited liability company

KND Real Estate 1, L.L.C., a Delaware limited liability company

KND Real Estate 2, L.L.C., a Delaware limited liability company

KND Real Estate 3, L.L.C., a Delaware limited liability company

KND Real Estate 4, L.L.C., a Delaware limited liability company

KND Real Estate 5, L.L.C., a Delaware limited liability company

KND Real Estate 6, L.L.C., a Delaware limited liability company

KND Real Estate 7, L.L.C., a Delaware limited liability company

KND Real Estate 10, L.L.C., a Delaware limited liability company

KND Real Estate 11, L.L.C., a Delaware limited liability company
KND Real Estate 12, L.L.C., a Delaware limited liability company
KND Real Estate 13, L.L.C., a Delaware limited liability company
KND Real Estate 15, L.L.C., a Delaware limited liability company
KND Real Estate 16, L.L.C., a Delaware limited liability company
KND Real Estate 17, L.L.C., a Delaware limited liability company
KND Real Estate 18, L.L.C., a Delaware limited liability company
KND Real Estate 19, L.L.C., a Delaware limited liability company
KND Real Estate 33, L.L.C., a Delaware limited liability company
KND Real Estate 34, L.L.C., a Delaware limited liability company
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KND Real Estate 36, L.L.C., a Delaware limited liability company
KND Real Estate 38, L.L.C., a Delaware limited liability company
KND Real Estate 39, L.L.C., a Delaware limited liability company
KND Real Estate 40, L.L.C., a Delaware limited liability company
KND Real Estate 48, L.L.C., a Delaware limited liability company
KND Real Estate 49, L.L.C., a Delaware limited liability company
KND Rehab Real Estate Holdings, L.L.C., a Delaware limited liability company
KND Real Estate 41, L.L.C., a Delaware limited liability company
KND Real Estate 42, L.L.C., a Delaware limited liability company
KND Real Estate 43, L.L.C., a Delaware limited liability company
KND Real Estate 44, L.L.C., a Delaware limited liability company
KND Real Estate 45, L.L.C., a Delaware limited liability company
KND Real Estate 50, L.L.C., a Delaware limited liability company
KND Real Estate 51, L.L.C., a Delaware limited liability company

Lafayette Health Care Center, Inc., a Georgia corporation

PersonaCare of Connecticut, Inc., a Connecticut corporation

Courtland Gardens Health Center, Inc., a Connecticut corporation

PersonaCare of Ohio, Inc., a Delaware corporation

PersonaCare of Reading, Inc., a Delaware corporation

PF Development 26, L.L.C., a Delaware limited liability company

PF Development 27, L.L.C., a Delaware limited liability company

RehabCare Group, Inc., a Delaware corporation

RehabCare Group Management Services, Inc., a Delaware corporation

Salt Lake Physical Therapy Associates, Inc., a Utah corporation

Centerre Healthcare Corporation, a Delaware corporation

CHC Management Services, LLC, a Missouri limited liability company

CRH of St. Louis, LLC, a Missouri limited liability company

CRH of Lancaster, LLC, a Missouri limited liability company

CRH of Dallas, LLC, a Missouri limited liability company

CRH of Waukesha, LLC, a Missouri limited liability company

CRH of Ft. Worth, LLC, a Delaware limited liability company

CRH of Oklahoma City, LLC, a Delaware limited liability company

CRH of Cleveland, LLC, a Delaware limited liability company

CRH of Indianapolis, LLC, a Delaware limited liability company

CRH of Langhome, LLC, a Delaware limited liability company

CRH of Springfield, LLC, a Delaware limited liability company

CRH of Memphis, LLC, a Delaware limited liability company

CRH of Madison, LLC, a Delaware limited liability company

CRH of Arlington, LLC, a Delaware limited liability company

CRH of Avon, LLC, a Delaware limited liability company

RehabCare Group East, Inc., a Delaware corporation

RehabCare Group of Texas, LLC, a Texas limited liability company

RehabCare Group of California, LLC, a Delaware limited liability company

American VitalCare, LLC, a California limited liability company

Symphony Health Services, LLC, a Delaware limited liability company

VTA Management Services, LLC, a Delaware limited liability company

VTA Staffing Services, LLC, a Delaware limited liability company

RehabCare Hospital Holdings, LLC, a Delaware limited liability company

Clear Lake Rehabilitation Hospital, LLC, a Delaware limited liability company

Lafayette Specialty Hospital, LLC, a Delaware limited liability company

Tulsa Specialty Hospital, LLC, a Delaware limited liability company

Northland LTACH, LLC, a Delaware limited liability company

CTRH, L.L.C., a Delaware limited liability company

St. Luke's Rehabilitation Hospital, LLC, a Delaware limited liability company

Greater Peoria Specialty Hospital, LLC, a Delaware limited liability company

Rhode Island Specialty Hospital, LLC, a Delaware limited liability company

The Specialty Hospital, LLC, a Georgia limited liability company

Dallas LTACH, LLC, a Delaware limited liability company

Triumph Rehabilitation Hospital Northern Indiana, LLC, an Indiana limited liability company

Triumph Rehabilitation Hospital of Northeast Houston, LLC, a Delaware limited liability company

Triumph Hospital Northwest Indiana, Inc., a Missouri corporation

Triumph Healthcare Holdings, Inc., a Delaware corporation

New Triumph Healthcare of Texas, LLC, a Texas limited liability company

Triumph Healthcare Third Holdings, LLC, a Delaware limited liability company

Triumph Healthcare Second Holdings, LLC, a Delaware limited liability company

New Triumph Healthcare, Inc., a Delaware corporation

SCCI Health Services Corporation, a Delaware corporation

SCCI Hospital Ventures, Inc., a Delaware corporation

SCCI Hospitals of America, Inc., a Delaware corporation

SCCI Hospital-El Paso, Inc., a Delaware corporation

SCCI Hospital-Mansfield, Inc., a Delaware corporation

Tucker Nursing Center, Inc., a Georgia corporation

Specialty Healthcare Services, Inc., a Delaware corporation

Southern California Specialty Care, Inc., a California corporation

Specialty Hospital of Cleveland, Inc., an Ohio corporation

Specialty Hospital of Philadelphia, Inc., a Pennsylvania corporation

Specialty Hospital of South Carolina, Inc., a South Carolina corporation

JB Thomas Hospital, Inc., a Massachusetts corporation

THC - Chicago, Inc., an Illinois corporation

THC - North Shore, Inc., an Illinois corporation

Kindred THC North Shore, LLC an Illinois limited liability company

THC - Houston, Inc., a Texas corporation

THC - Orange County, Inc., a California corporation

THC - Seattle, Inc., a Washington corporation

Transitional Hospitals Corporation of Indiana, Inc., an Indiana corporation

Transitional Hospitals Corporation of Louisiana, Inc., a Louisiana corporation

Transitional Hospitals Corporation of New Mexico, Inc., a New Mexico corporation

Transitional Hospitals Corporation of Nevada, Inc., a Nevada corporation

Transitional Hospitals Corporation of Tampa, Inc., a Florida corporation

Transitional Hospitals Corporation of Texas, Inc., a Texas corporation

Transitional Hospitals Corporation of Wisconsin, Inc., a Wisconsin corporation

Gentiva Health Services, Inc., a Delaware corporation

Odyssey HealthCare Inc., a Delaware corporation

Odyssey HealthCare Holding Company, a Delaware corporation

Odyssey HealthCare GP, LLC, a Delaware limited liability company

Odyssey HealthCare LP, LLC, a Delaware limited liability company

VistaCare, LLC, a Delaware limited liability company

Vista Hospice Care, LLC, a Delaware limited liability company

VistaCare USA, LLC, a Delaware limited liability company

FHI Health Systems, Inc., a Delaware corporation

FHI GP, Inc., a Texas corporation

FHI LP, Inc., a Nevada corporation

Gentiva Health Services Holding Corp., a Delaware corporation

Gentiva Health Services (Certified), Inc., a Delaware corporation

Gentiva Certified Healthcare Corp., a Delaware corporation

PHHC Acquisition Group, a Delaware corporation

Gilbert's Hospice Care, LLC, a Mississippi limited liability company

Gilbert's Hospice Care of Mississippi, LLC, a Mississippi limited liability company

Home Health Care Affiliates of Central Mississippi, LLC, a Mississippi limited liability company

Home Health Care Affiliates of Mississippi, Inc., a Mississippi corporation

Home Health Care Affiliates, Inc., a Mississippi corporation

Gilbert's Home Health Agency, Inc., a Mississippi corporation

Van Winkle Home Health Care, Inc., a Mississippi corporation

Gentiva Health Services (USA) LLC, a Delaware limited liability company

Gentiva Services of New York, Inc., a New York corporation

New York Healthcare Services, Inc., a New York corporation

OHS Service Corp., a Texas corporation

QC-Medi New York, Inc., a New York corporation

Quality Care-USA, Inc., a New York corporation

Gentiva Insurance Corporation, a New York corporation

Healthfield Operating Group, LLC, a Delaware limited liability company

Healthfield, LLC, a Delaware limited liability company

Chattahoochee Valley Home Care Services, LLC, a Georgia limited liability company

Chattahoochee Valley Home Health, LLC, a Georgia limited liability company

CHMG Acquisition LLC, a Georgia limited liability company

Capital Health Management Group, LLC, a Georgia limited liability company

Access Home Health of Florida, LLC, a Delaware limited liability company

Capital Care Resources, LLC, a Georgia limited liability company

Capital Care Resources of South Carolina, LLC, a Georgia limited liability company

CHMG of Atlanta, LLC, a Georgia limited liability company

CHMG of Griffin, LLC, a Georgia limited liability company

Eastern Carolina Home Health Agency, LLC, a North Carolina limited liability company

Home Health Care of Carteret County, LLC, a North Carolina limited liability company

Tar Heel Health Care Services, LLC, a North Carolina limited liability company

Healthfield Home Health, LLC, a Georgia limited liability company

Healthfield Hospice Services, LLC, a Georgia limited liability company

Healthfield of Southwest Georgia, LLC, a Georgia limited liability company

Healthfield of Statesboro, LLC, a Georgia limited liability company

Healthfield of Tennessee, LLC, a Georgia limited liability company

Mid-South Home Health, LLC, a Georgia limited liability company

Mid-South Home Health of Gadsden, LLC, a Georgia limited liability company

Total Care Home Health of Louisburg, LLC, a Georgia limited liability company

Total Care Home Health of North Carolina, LLC, a Georgia limited liability company

Total Care Home Health of South Carolina, LLC, a Georgia limited liability company

Wiregrass Hospice Care, LLC, a Georgia limited liability company

Horizon Health Network, LLC, an Alabama limited liability company

Mid-South Home Health Agency, LLC, an Alabama limited liability company

Mid-South Home Care Services, LLC, an Alabama limited liability company

Wiregrass Hospice, LLC, an Alabama limited liability company

Wiregrass Hospice of South Carolina, LLC, a Georgia limited liability company

Harden Healthcare Holdings, LLC, a Delaware limited liability company

Harden Healthcare, LLC, a Texas limited liability company

Harden HC Texas Holdco, LLC, a Texas limited liability company

Harden Clinical Services, LLC, a Texas limited liability company

Harden Healthcare Services, LLC, a Texas limited liability company

Harden Home Option, LLC, a Texas limited liability company

The Home Option, LLC, a Texas limited liability company

Lighthouse Hospice Partners, LLC, a Texas limited liability company

Harden Hospice, LLC, a Texas limited liability company

Bethany Hospice, LLC, a Delaware limited liability company

California Hospice, LLC, a Texas limited liability company

Georgia Hospice, LLC, a Texas limited liability company

Lighthouse Hospice-Coastal Bend, LLC, a Texas limited liability company

Lighthouse Hospice Management, LLC, a Texas limited liability company

Lighthouse Hospice-Metroplex, LLC, a Texas limited liability company

ABC Hospice, LLC, a Texas limited liability company

Lighthouse Hospice-San Antonio, LLC, a Texas limited liability company

Harden Home Health, LLC, a Delaware limited liability company

Asian American Home Care, Inc., a California corporation

First Home Health, Inc., a West Virginia corporation

Nursing Care-Home Health Agency Inc., a West Virginia corporation

Faith in Home Services, LLC, a Kansas limited liability company

Faith Home Health and Hospice, LLC, a Kansas limited liability company

Girling Health Care Services of Knoxville, Inc., a Tennessee corporation

Girling Health Care, Inc., a Texas corporation

Hawkeye Health Services, Inc., an Iowa corporation

Horizon Health Care Services, Inc., a Texas corporation

Missouri Home Care of Rolla, Inc., a Missouri corporation

American HomeCare Management Corp., a Delaware corporation

The Home Team of Kansas, LLC, a Kansas limited liability company

Voyager Hospice Care, Inc., a Delaware corporation

Hospice Care of Kansas, LLC, a Kansas limited liability company

Hospice Care of Kansas and Missouri, LLC, a Missouri limited liability company

Hospice Care of the Midwest, LLC,
a Missouri limited liability
company

Colorado Hospice, LLC, a Colorado limited liability
company

The American Heartland Hospice Corp., a Missouri
corporation

Iowa Hospice, LLC, an Iowa limited liability company

Lakes Hospice, LLC, an Iowa limited liability
company

American Hospice, Inc., a Texas corporation

Chaparral Hospice, Inc., a Texas corporation

Voyager Home Health, Inc., a Delaware corporation

Alpine Home Health Care, LLC, a Colorado
limited liability company

Alpine Home Health II, Inc., a Colorado
corporation

Alpine Home Health, Inc., a Mississippi
corporation

Alpine Resource Group, Inc., a Colorado
corporation

Saturday Partners, LLC, a Colorado limited
liability company

Isidora's Health Care, Inc., a Texas corporation

Partnerships, Joint Ventures and Non-Profits

KHOI New Limited Partnership, a Delaware limited partnership

Kindred Hospitals Limited Partnership, a Delaware limited partnership

Kindred Nursing Centers Limited Partnership, a Delaware limited partnership

Fox Hill Village Partnership, a Massachusetts general partnership

Starr Farm Partnership, a Vermont general partnership

Hillhaven-MSD Partnership, a California general partnership

New Triumph Healthcare, LLP, a Texas limited partnership

RehabCare Group of Arlington, LP, a Texas limited partnership

RehabCare Group of Amarillo, LP, a Texas limited partnership

Triumph Hospital of North Houston, L.P., a Texas limited partnership

Triumph Hospital of East Houston, L.P., a Texas limited partnership

Triumph Southwest, L.P., a Texas limited partnership

Family Hospice, Ltd., a Texas limited partnership

FHI Management, Ltd., a Texas limited partnership

Odyssey HealthCare Management, LP, a Delaware limited partnership

Odyssey HealthCare Operating A, LP, a Delaware limited partnership

Voyager Acquisition, L.P., a Texas limited partnership

Odyssey HealthCare Operating B, LP, a Delaware limited partnership

Odyssey HealthCare of Augusta, LLC, a Delaware limited liability company

Odyssey HealthCare of Austin, LLC, a Delaware limited liability company

Odyssey HealthCare of Detroit, LLC, a Delaware limited liability company

Odyssey HealthCare of Fort Worth, LLC, a Delaware limited liability company

Odyssey HealthCare of Flint, LLC, a Delaware limited liability company

Odyssey HealthCare of Marion County, LLC, a Delaware limited liability company

Odyssey HealthCare of Savannah, LLC, a Delaware limited liability company

Odyssey HealthCare of St. Louis, LLC, a Delaware limited liability company

VistaCare of Boston, LLC, a Delaware limited liability company

Odyssey HealthCare of Kansas City, LLC, a Delaware limited liability company

Odyssey HealthCare of South Texas, LLC, a Delaware limited liability company

Wake Forest Baptist Health Care at Home, LLC, a North Carolina limited liability company

CTRH, L.L.C., a Delaware limited liability company

Dallas LTACH, LLC, a Delaware limited liability company

Greater Peoria Specialty Hospital, L.L.C., a Delaware limited liability company

Rhode Island Specialty Hospital, LLC, a Delaware limited liability company

St. Luke's Rehabilitation Hospital, LLC, a Delaware limited liability company

The Specialty Hospital, LLC, a Georgia limited liability company

Avon RH, LLC, a Delaware limited liability company

Beachwood RH, LLC, a Delaware limited liability company

Lancaster Rehabilitation Hospital, a Delaware limited liability company

Mercy Rehabilitation Hospital-St. Louis, LLC, a Missouri limited liability company

Mercy Rehabilitation Hospital Springfield, LLC, a Missouri limited liability company

Mercy Rehabilitation Hospital, LLC, an Oklahoma limited liability company

Rehabilitation Hospital of Wisconsin, LLC, a Delaware limited liability company

Texas Rehabilitation Hospital of Arlington, LLC, a Texas limited liability company

Texas Rehabilitation Hospital of Fort Worth, LLC, a Texas limited liability company

Hospice of the Emerald Coast, Inc., a Florida corporation

Saint Thomas Rehabilitation Hospital, LLC, a Tennessee limited liability company

Atlantic Rehabilitation Institute, LLC, a New Jersey limited liability company

Mercy Rehabilitation Hospital, LLC, an Iowa limited liability company

Northwest Washington Rehabilitation Hospital, LLC, a Washington limited liability company

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statement on Form S-8 (Nos. 333-59598, 333-62022, 333-88086, 333-116755, 333-151580, 333-174615, 333-183269, 333-197755, 333-201830, 333-201831, 333-204550 and 333-218199) of Kindred Healthcare, Inc. of our report dated February 28, 2018 relating to the financial statements, financial statement schedule, and the effectiveness of internal control over financial reporting, which appears in this Form 10-K.

/s/ PricewaterhouseCoopers LLP
Louisville, Kentucky
February 28, 2018

**Certification Required By Rules 13a-14(a) and 15d-14(a)
under the Securities Exchange Act of 1934**

I, Benjamin A. Breier, certify that:

1. I have reviewed this annual report on Form 10-K of Kindred Healthcare, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
 - (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
 - (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
 - (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
 - (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
 - (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 28, 2018

/s/ Benjamin A. Breier

Benjamin A. Breier

President and Chief Executive Officer

**Certification Required By Rules 13a-14(a) and 15d-14(a)
under the Securities Exchange Act of 1934**

I, Stephen D. Farber, certify that:

1. I have reviewed this annual report on Form 10-K of Kindred Healthcare, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
 - (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
 - (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
 - (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
 - (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
 - (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 28, 2018

/s/ Stephen D. Farber

Stephen D. Farber

Executive Vice President, Chief Financial Officer

Section 1350 Certifications
Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
(Subsections (a) and (b) of Section 1350, Chapter 63 of Title 18, United States Code)

Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 (subsections (a) and (b) of Section 1350, Chapter 63 of Title 18, United States Code), each of the undersigned officers of Kindred Healthcare, Inc., a Delaware corporation (the "Company"), does hereby certify, to such officer's knowledge, that:

The Annual Report on Form 10-K for the year ended December 31, 2017 (the "Form 10-K") of the Company fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934 and information contained in the Form 10-K fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: February 28, 2018

/s/ Benjamin A. Breier

Benjamin A. Breier
President and Chief Executive Officer

Date: February 28, 2018

/s/ Stephen D. Farber

Stephen D. Farber
Executive Vice President, Chief Financial Officer

Kindred Healthcare, LLC

Combined Financial Statements for the period January 1 – July 1, 2018 of Kindred Hospital Company (A carve-out business of Kindred Healthcare, Inc.) and Consolidated Financial Statements for the period July 2 – December 31, 2018 of Kindred Healthcare, LLC

KINDRED HEALTHCARE, LLC
INDEX TO CONSOLIDATED FINANCIAL STATEMENTS

	<u>Page</u>
Reports of Independent Auditors	2
Combined Financial Statements of Kindred Hospital Company:	
Combined Statement of Operations for the period January 1 – July 1, 2018	4
Combined Statement of Comprehensive Loss for the period January 1 – July 1, 2018	5
Combined Statement of Members’ Equity for the period January 1 – July 1, 2018.....	7
Combined Statement of Cash Flows for the period January 1 – July 1, 2018.....	8
Consolidated Financial Statements of Kindred Healthcare, LLC:	
Consolidated Statement of Operations for the period July 2 – December 31, 2018.....	4
Consolidated Statement of Comprehensive Loss for the period July 2 – December 31, 2018.....	5
Consolidated Balance Sheet as of December 31, 2018	6
Consolidated Statement of Members’ Equity for the period July 2 – December 31, 2018	7
Consolidated Statement of Cash Flows for the period July 2 – December 31, 2018	8
Notes to Consolidated Financial Statements	9



Report of Independent Auditors

To the Board of Directors of Kindred Healthcare, LLC

We have audited the accompanying consolidated financial statements of Kindred Healthcare, LLC and its subsidiaries (Successor Company), which comprise the consolidated balance sheet as of December 31, 2018 and the related consolidated statements of operations, comprehensive loss, members' equity, and cash flows for the period from July 2, 2018 to December 31, 2018.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Successor Company's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Successor Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Kindred Healthcare, LLC and its subsidiaries (Successor Company) as of December 31, 2018 and the results of their operations and their cash flows for the period from July 2, 2018 to December 31, 2018 in accordance with accounting principles generally accepted in the United States of America.

A handwritten signature in black ink that reads "PricewaterhouseCoopers LLP".

March 4, 2019

PricewaterhouseCoopers LLP, 500 West Main Street, Suite 1800, Louisville, Kentucky 40202-2941
T: (502) 589 6100, F: (502) 585 7875, www.pwc.com



Report of Independent Auditors

To the Board of Directors of Kindred Healthcare, LLC

We have audited the accompanying combined financial statements of Kindred Hospital Company (a carve-out business of Kindred Healthcare, Inc.) and its subsidiaries (Predecessor Company), which comprise the combined statements of operations, comprehensive loss, members' equity, and cash flows for the period from January 1, 2018 to July 1, 2018.

Management's Responsibility for the Combined Financial Statements

Management is responsible for the preparation and fair presentation of the combined financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on the combined financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Predecessor Company's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Predecessor Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the results of Kindred Hospital Company (a carve-out business of Kindred Healthcare, Inc.) and its subsidiaries (Predecessor Company) operations and their cash flows for the period from January 1, 2018 to July 1, 2018 in accordance with accounting principles generally accepted in the United States of America.

PricewaterhouseCoopers LLP

March 4, 2019

*PricewaterhouseCoopers LLP, 500 West Main Street, Suite 1800, Louisville, Kentucky 40202-2941
T: (502) 589 6100, F: (502) 585 7875, www.pwc.com*

KINDRED HEALTHCARE, LLC
CONSOLIDATED STATEMENTS OF OPERATIONS
(In thousands)

	Successor Company	Predecessor Company
	July 2 – December 31, 2018	January 1 – July 1, 2018
Revenues	\$ 1,613,262	\$ 1,706,744
Salaries, wages and benefits	1,051,471	1,108,206
Supplies	103,324	113,903
Building rent	97,374	100,794
Equipment rent	16,279	16,439
Other operating expenses	283,785	242,016
Other income	(27,037)	(2,642)
Litigation contingency expense	1,912	1,432
Restructuring charges (Note 5)	55,351	11,824
Depreciation and amortization	32,755	40,736
Sponsor fees and value capture initiatives (Note 17)	8,146	–
Interest expense	22,548	124,029
Investment income	(397)	(261)
	<u>1,645,511</u>	<u>1,756,476</u>
Loss from continuing operations before income taxes	(32,249)	(49,732)
Provision for income taxes (Note 6)	566	1,766
Loss from continuing operations	(32,815)	(51,498)
Discontinued operations, net of income taxes (Note 4):		
Income from discontinued operations	7,217	245
Loss on divestiture of operations	(5,830)	(7,893)
Income (loss) from discontinued operations	<u>1,387</u>	<u>(7,648)</u>
Net loss	(31,428)	(59,146)
Earnings attributable to noncontrolling interests:		
Continuing operations	(20,891)	(21,202)
Discontinued operations	(80)	(700)
	<u>(20,971)</u>	<u>(21,902)</u>
Loss attributable to Successor Company	<u>\$ (52,399)</u>	
Loss attributable to Predecessor Company		<u>\$ (81,048)</u>
Amounts attributable to Kindred:		
Loss from continuing operations	\$ (53,706)	\$ (72,700)
Income (loss) from discontinued operations	1,307	(8,348)
Net loss	<u>\$ (52,399)</u>	<u>\$ (81,048)</u>

See accompanying notes to the consolidated financial statements.

KINDRED HEALTHCARE, LLC
CONSOLIDATED STATEMENTS OF COMPREHENSIVE LOSS
(In thousands)

	<u>Successor Company</u>	<u>Predecessor Company</u>
	<u>July 2 – December 31, 2018</u>	<u>January 1 – July 1, 2018</u>
Net loss	\$ (31,428)	\$ (59,146)
Other comprehensive loss:		
Interest rate swap (Notes 1 and 10):		
Change in unrealized gains (losses)	(7,086)	4,125
Reclassification of settlement gain in net loss	–	(9,874)
Reclassification of gains realized in net loss, net of payments	–	(816)
Net change	<u>(7,086)</u>	<u>(6,565)</u>
Defined benefit post-retirement plan:		
Unrealized loss due to fair value adjustments	<u>(408)</u>	<u>–</u>
Other comprehensive loss	<u>(7,494)</u>	<u>(6,565)</u>
Comprehensive loss	(38,922)	(65,711)
Earnings attributable to noncontrolling interests	<u>(20,971)</u>	<u>(21,902)</u>
Comprehensive loss attributable to Successor Company	<u>\$ (59,893)</u>	
Comprehensive loss attributable to Predecessor Company		<u>\$ (87,613)</u>

See accompanying notes to the consolidated financial statements.

KINDRED HEALTHCARE, LLC
CONSOLIDATED BALANCE SHEET
(In thousands)

	<u>Successor Company</u> <u>December 31,</u> <u>2018</u>
ASSETS	
Current assets:	
Cash and cash equivalents	\$ 84,213
Insurance subsidiary investments	6,951
Accounts receivable less allowance for loss of \$56,492	693,339
Inventories	20,486
Income taxes	2,299
Assets held for sale	53,054
Other (Note 14)	47,956
	908,298
Property and equipment, at cost:	
Land	56,044
Buildings	205,750
Equipment	159,854
Construction in progress	47,530
	469,178
Accumulated depreciation	(28,415)
	440,763
Goodwill	320,963
Intangible assets less accumulated amortization of \$15,469	199,905
Insurance subsidiary investments	24,662
Other (Note 14)	238,580
Total assets (a)	\$ 2,133,171
LIABILITIES AND MEMBERS' EQUITY	
Current liabilities:	
Accounts payable	\$ 114,458
Salaries, wages and other compensation	232,934
Due to third party payors	42,309
Professional liability risks	41,205
Accrued lease termination fees	8,081
Other accrued liabilities (Note 14)	230,341
Long-term debt due within one year	4,433
	673,761
Long-term debt	455,760
Professional liability risks	233,732
Deferred credits and other liabilities (Note 14)	410,430
Commitments and contingencies (Note 11)	
Members' equity:	
Members' investment	224,201
Accumulated other comprehensive loss	(7,494)
Accumulated deficit	(52,399)
	164,308
Noncontrolling interests	195,180
Total members' equity	359,488
Total liabilities (a) and members' equity	\$ 2,133,171

(a) The Company's consolidated assets as of December 31, 2018 include total assets of variable interest entities of \$375.2 million, which can only be used to settle the obligations of the variable interest entities. The Company's consolidated liabilities as of December 31, 2018 include total liabilities of variable interest entities of \$46.4 million. See note 1 of the notes to consolidated financial statements.

See accompanying notes to the consolidated financial statements.

KINDRED HEALTHCARE, LLC
CONSOLIDATED STATEMENTS OF MEMBERS' EQUITY
(In thousands)

	Shares of common stock	Par value common stock	Members' investment	Accumulated other comprehensive income (loss)	Accumulated deficit	Noncontrolling interests	Total
Predecessor Company:							
Balances, December 31, 2017	91,454	\$ 22,864	\$ (158,859)	\$ 6,179	\$ (1,892,097)	\$ 220,766	\$ (1,801,147)
Adoption of new revenue standard					(5,268)		(5,268)
Comprehensive loss:							
Net income (loss)					(81,048)	21,902	(59,146)
Other				(6,565)			(6,565)
Comprehensive loss							(65,711)
Cancellation of non-vested restricted stock	(67)	(17)	17				-
Issuance of common stock in connection with employee benefit plans	203	51	(51)				-
Shares tendered by employees for statutory tax withholdings upon issuance of common stock	(479)	(120)	(4,166)		(64)		(4,350)
Stock-based compensation amortization			6,612				6,612
Contributions made by noncontrolling interests						11,001	11,001
Distributions to noncontrolling interests						(42,841)	(42,841)
Transfers from Kindred at Home, net			102,887				102,887
Balances, July 1, 2018	91,111	22,778	(53,560)	(386)	(1,978,477)	210,828	(1,798,817)
Successor Company:							
Balances, July 2, 2018	91,111	\$ 22,778	\$ (53,560)	\$ (386)	\$ (1,978,477)	\$ 210,828	\$ (1,798,817)
Split of company to private investors	(91,111)	(22,778)	53,560	386	1,978,477	(15,768)	1,993,877
Proceeds from parent investors			219,896				219,896
Comprehensive loss:							
Net income (loss)					(52,399)	20,971	(31,428)
Other				(7,494)			(7,494)
Comprehensive loss							(38,922)
Equity unit buy-in program			3,780				3,780
Service-vested profit units compensation amortization			525				525
Contributions made by noncontrolling interests						2,190	2,190
Distributions to noncontrolling interests						(22,783)	(22,783)
Purchase of noncontrolling interests						(258)	(258)
Balances, December 31, 2018	-	\$ -	\$ 224,201	\$ (7,494)	\$ (52,399)	\$ 195,180	\$ 359,488

See accompanying notes to the consolidated financial statements.

KINDRED HEALTHCARE, LLC
CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)

	Successor Company July 2 – December 31, 2018	Predecessor Company January 1 – July 1, 2018
Cash flows from operating activities:		
Net loss	\$ (31,428)	\$ (59,146)
Adjustments to reconcile net loss to net cash used in operating activities:		
Depreciation expense	28,415	39,841
Amortization of intangible assets	4,340	4,292
Amortization of leasehold interest assets and liabilities, net	(9,495)	549
Amortization of deferred compensation costs	525	6,612
Amortization of deferred financing costs	1,636	8,511
Provision for doubtful accounts	(1,323)	(2,072)
Deferred income taxes	89	654
Loss on divestiture of discontinued operations	5,830	7,893
Other	(843)	747
Change in operating assets and liabilities:		
Accounts receivable	44,759	2,046
Inventories and other assets	175,268	(124,816)
Accounts payable	(16,338)	(41,584)
Income taxes	358	(1,104)
Due to third party payors	23,939	(7,594)
Other accrued liabilities	(255,471)	52,099
Net cash used in operating activities	<u>(29,739)</u>	<u>(113,072)</u>
Cash flows from investing activities:		
Routine capital expenditures	(31,580)	(23,701)
Development capital expenditures	(7,546)	(11,615)
Sale of assets	11,771	21,217
Net change in other investments	(1,782)	(4,329)
Other	343	(417)
Net cash used in investing activities	<u>(28,794)</u>	<u>(18,845)</u>
Cash flows from financing activities:		
Proceeds from borrowings under revolving credit	507,000	757,000
Repayment of borrowings from revolving credit	(442,700)	(744,900)
Proceeds from issuance of term loan, net of discount	405,900	–
Repayment of term loan	(1,025)	(7,017)
Repayment of other long-term debt	(217)	(384)
Payment of deferred financing costs	(18,561)	(119)
Distribution to Kindred equity holders	(754,249)	–
Net transfers from Kindred at Home	166,441	103,587
Proceeds from parent investors	219,896	–
Equity unit buy-in program	3,780	–
Tax payments for equity awards issuance	–	(4,350)
Contributions made by noncontrolling interests	2,190	626
Distributions to noncontrolling interests	(22,783)	(42,841)
Purchase of noncontrolling interests	(258)	–
Net cash provided by financing activities	<u>65,414</u>	<u>61,602</u>
Change in cash, cash equivalents and restricted cash	6,881	(70,315)
Cash, cash equivalents and restricted cash at beginning of period	126,275	196,590
Cash, cash equivalents and restricted cash at end of period	<u>\$ 133,156</u>	<u>\$ 126,275</u>
Supplemental information:		
Interest payments	\$ 19,766	\$ 110,708
Income tax payments	404	514
Rental payments to Ventas, Inc.	61,658	60,747
Non-cash contributions made by noncontrolling interests	–	10,375

See accompanying notes to the consolidated financial statements.

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1 – BASIS OF PRESENTATION

Reporting entity

Kindred Healthcare, LLC is a healthcare services company that through its subsidiaries operates transitional care (“TC”) hospitals (certified as long-term acute care (“LTAC”) hospitals under the Medicare program), inpatient rehabilitation hospitals (“IRFs”), and a contract rehabilitation services business across the United States (collectively, the “Company” or the “Successor Company”). For purposes of these statements and related notes, the successor period is being presented on a consolidated basis for the Company and the predecessor period is being presented on a combined basis for Kindred Hospital Company (a carve-out business of Kindred Healthcare, Inc.) (the “Predecessor Company”).

The accompanying financial statements present the consolidated (for successor period) and combined (for predecessor period) changes in members’ equity, revenues, expenses and cash flows of the Successor Company and Predecessor Company, respectively, excluding Gentiva Health Services, Inc. (d/b/a Kindred at Home) (“KAH”). Through July 1, 2018, KAH was an operating division of Kindred Healthcare, Inc. (“Kindred”) and primarily provided home health, hospice and community care services for patients in a variety of settings, including their homes, nursing centers and other residential settings. KAH has been excluded from the Predecessor Company accompanying combined financial statements and was considered a related party.

Reorganization of Kindred

On July 2, 2018, Kindred was acquired by a consortium of three companies: TPG Capital (“TPG”), Welsh, Carson, Anderson & Stowe (“WCAS”) and Humana Inc. (“Humana”) for approximately \$4.3 billion in cash including the assumption or repayment of net debt (the “Kindred Reorganization”). Under the terms of the Merger Agreement (as defined herein), stockholders of Kindred received \$9.00 in cash for each share of Kindred common stock they held.

Immediately following the acquisition of Kindred, KAH (formerly an operating division of Kindred) was separated from Kindred and now operates as a stand-alone company owned 40% by Humana, with the remaining 60% of KAH owned by TPG and WCAS. The Company now operates as a separate specialty hospital company owned primarily by TPG and WCAS. See Note 2.

As used in these financial statements, the term “Predecessor Company” refers to the Company and its operations for the period January 1, 2018 through July 1, 2018, while the term “Successor Company” is used to describe the Company and its operations for the period July 2, 2018 through December 31, 2018.

In connection with the Kindred Reorganization, the Company revalued all assets and liabilities. For accounting purposes, these adjustments have been recorded in the consolidated financial statements as of July 2, 2018. Since the Kindred Reorganization materially changed the amounts previously recorded in the Company’s consolidated financial statements, a black line separates the Successor Company from the Predecessor Company to signify the difference in the basis of presentation of the financial statements for each respective entity.

Basis of presentation

The Predecessor Company has not historically constituted a separate legal entity and stand-alone financial statements had not previously been prepared for the Predecessor Company. The accompanying combined financial statements of the Predecessor Company have been prepared on a stand-alone basis derived from the financial statements and related accounting records of Kindred and reflect the historical results of operations, financial position, and cash flows of the Predecessor Company as they were historically managed for the period January 1, 2018 through July 1, 2018.

The accompanying consolidated financial statements of the Successor Company and the accompanying combined financial statements of the Predecessor Company include all subsidiaries that the Company controls, including variable interest entities (“VIEs”) for which the Company is the primary beneficiary. All intercompany transactions have been eliminated.

The Company has completed several transactions related to the divestiture of unprofitable hospitals and nursing centers to improve its future operating results. Kindred has completed the SNF Divestiture (as defined and described more fully in Note 3). For accounting purposes, the operating results of these businesses and the losses associated with these transactions have been classified as discontinued operations in the accompanying consolidated statement of operations and accompanying combined statement of operations for all periods presented.

The accompanying consolidated financial statements and accompanying combined financial statements have been prepared in accordance with United States generally accepted accounting principles (“GAAP”) and include amounts based upon the estimates and judgments of management. Actual amounts may differ from those estimates.

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Principles of combination

The Predecessor Company financial statements reflect allocations of direct and indirect expenses to KAH related to certain support functions provided by Kindred. Management believes the assumptions underlying the Predecessor Company financial statements, including the assumptions regarding allocation of expenses, are reasonable. Nevertheless, the Predecessor Company financial statements may not include all of the actual expenses that would have been incurred by the Company and may not reflect the Company's financial position, results of operations and cash flows that would have been reported if the Company had been a stand-alone entity during the period presented. See Note 17.

Recently issued accounting requirements

In November 2018, the Financial Accounting Standards Board (the "FASB") issued a clarification of existing authoritative guidance stating that elements of collaborative arrangements could qualify as transactions with customers in the scope of the New Revenue Standard (as defined herein). The guidance precludes an entity from presenting consideration from a transaction in a collaborative arrangement as revenue from contracts with customers if the counterparty is not a customer for that transaction. For nonpublic entities, the amendment is effective for fiscal years beginning after December 15, 2020, and early adoption is permitted. The Company will not elect to early adopt and the adoption of the amendment is not expected to have a material impact on the Company's business, financial position, results of operations or liquidity.

In October 2018, the FASB amended authoritative guidance of derivatives and hedging to allow the Overnight Index Swap rate based on the Secured Overnight Financing Rate as a benchmark rate for hedge accounting purposes should the London Interbank Offered Rate ("LIBOR") no longer be sustainable. Since the Company has not already adopted the 2017 amendment Targeted Improvements to Accounting for Hedging Activities, the amendments will be required to be adopted concurrently with the 2017 amendment, or for annual periods beginning after December 15, 2019. The adoption of these amendments are not expected to have an impact on the Company's business, financial position, results of operations or liquidity.

In August 2018, the FASB issued amended authoritative guidance which changes the fair value measurement disclosure requirements. The amendment removes disclosure requirements for timing of transfers between hierarchy levels, Level 3 valuation processes, and changes in unrealized gains and losses for recurring Level 3 fair value measurements held at the end of the reporting period. The amendment modifies existing requirements to disclose purchases, issuances, and transfers into and out of Level 3 assets and liabilities. The amendment is effective for all entities for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2019. The amendment should be applied retrospectively to all periods presented upon their effective date. Early adoption is permitted. The Company will not elect to early adopt and the adoption of the amendment is not expected to have a material impact on the Company's business, financial position, results of operations or liquidity.

In August 2018, the FASB issued amended authoritative guidance which aligns the requirements for capitalizing implementation costs incurred in a cloud computing arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software. The capitalized implementation costs are to be expensed over the term of the hosted arrangement to the same line item as the fees associated with the hosting element. The new guidance is effective for nonpublic entities for annual reporting periods beginning after December 15, 2020, and interim periods within annual periods beginning after December 15, 2021. Early adoption of the amendment is permitted, including adoption in any interim period, for all entities. The amendment should be applied either retrospectively or prospectively to all implementation costs incurred after the date of adoption. The Company will early adopt the amended guidance in 2019 on a prospective basis and does not expect a material impact to its business, financial position, results of operations, or liquidity.

In August 2017, the FASB issued amended authoritative guidance with the objective of improving the financial reporting of hedging relationships under GAAP to better portray economic results and to simplify the application of the current hedge accounting guidance. The new guidance is effective for annual periods beginning after December 15, 2019, interim periods within annual periods beginning after December 15, 2020, and early adoption is permitted. The Company will not elect to early adopt and the adoption of the amendment is not expected to have a material impact on the Company's business, financial position, results of operations or liquidity.

In June 2016, the FASB issued amended authoritative guidance for accounting for credit losses on financial instruments. The new guidance introduces an approach based on expected losses to estimate credit losses on certain types of financial instruments and modifies the impairment model for available-for-sale debt securities. The new guidance is effective for annual periods beginning after December 15, 2021 and early adoption is permitted. The Company will not elect to early adopt and the adoption of the amendment is not expected to have a material impact on the Company's business, financial position, results of operations, and liquidity.

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Recently issued accounting requirements (Continued)

In February 2016, the FASB issued amended authoritative guidance on accounting for leases. The new provisions require that a lessee of operating leases recognize in the statement of financial position a liability to make lease payments (the lease liability) and a right-of-use asset representing its right to use the underlying asset for the lease term. The lease liability will be equal to the present value of lease payments, with the right-of-use asset based upon the lease liability. The classification criteria for distinguishing between finance (or capital) leases and operating leases are substantially similar to the previous lease guidance, but with no explicit bright lines. As such, operating leases will result in straight-line rent expense similar to current practice. For short term leases (term of 12 months or less), a lessee is permitted to make an accounting election not to recognize lease assets and lease liabilities, which would generally result in lease expense being recognized on a straight-line basis over the lease term. The guidance is effective for annual periods beginning after December 15, 2019, and interim periods within annual periods beginning after December 15, 2020.

The Company will not elect early adoption and will apply the modified retrospective approach with the election of the practical expedients, therefore not electing the use of hindsight. The adoption of this standard is expected to have a material impact on the Company's financial position. Management continues to evaluate the effect on the Company's consolidated financial statements. The Company does not expect that this authoritative guidance will have a material impact on its business, results of operations or liquidity.

Revenues

On January 1, 2018, the Predecessor Company adopted Accounting Standards Codification ("ASC") 606, *Revenue from Contracts with Customers*, and all of the related amendments (the "New Revenue Standard"). The New Revenue Standard requires entities to recognize the amount of revenue it expects for the transfer of goods or services to customers. The adoption of this standard had an immaterial impact on the Predecessor Company's reported total revenues as compared to what reported amounts would have been under the prior standard, and the Company expects the impact of adoption in future periods will be immaterial. The Company's accounting policies under the New Revenue Standard were applied prospectively and are noted below.

Revenues are recognized as performance obligations are satisfied, which is over time as patient services are rendered throughout the length of stay, in an amount that reflects the consideration the Company expects to receive in exchange for services. A performance obligation is defined as a promise in a contract to transfer a distinct good or service to the customer. Substantially all of the Company's contracts with patients and customers have a single performance obligation as the promise to transfer services is not distinct or separately identifiable from other promises in the contract.

The transaction price for the Company's contracts represents its best estimate of the consideration the Company expects to receive and includes assumptions regarding variable consideration as applicable. These variable considerations include estimated amounts due from patients and third party payors for healthcare services provided, including anticipated settlements under reimbursement agreements with Medicare, Medicaid, Medicare Advantage, Medicaid Managed, and other third party payors. Revenues under third party agreements are subject to examination and retroactive adjustment. Provisions for estimated third party adjustments are provided in the period the related services are rendered to the extent it is probable that a significant reversal of cumulative revenue will not occur. Any remaining differences between the amounts accrued and subsequent settlements are recorded in the periods in which the interim or final settlements are determined.

A summary of revenues by payor type follows (in thousands):

	<u>Successor Company</u>	<u>Predecessor Company</u>
	<u>July 2 – December 31, 2018</u>	<u>January 1 – July 1, 2018</u>
Medicare	\$ 575,527	\$ 629,814
Medicaid	55,017	50,715
Medicare Advantage	169,077	180,889
Medicaid Managed	110,309	112,622
Other	738,809	773,798
	<u>1,648,739</u>	<u>1,747,838</u>
Eliminations	(35,477)	(41,094)
	<u>\$ 1,613,262</u>	<u>\$ 1,706,744</u>

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

ASC 606 adoption impact

On January 1, 2018, the Predecessor Company adopted the New Revenue Standard using the modified retrospective transition method. The Predecessor Company recognized the cumulative effect of initially applying the New Revenue Standard to all contracts not completed as of the date of adoption, resulting in a \$5.3 million adjustment, net of taxes, on January 1, 2018 to accounts receivable and accumulated deficit. The impact of adoption of the New Revenue Standard was primarily related to recognizing contractual revenues earlier due to variable considerations arising from the historical collectability of the Predecessor Company’s hospital division’s private payor portfolio (included within the other payor type).

The Company reclassified approximately \$0.4 million and \$0.7 million of other operating expenses to contractual revenues for the Successor Company for the period July 2, 2018 through December 31, 2018 and for the Predecessor Company for the period January 1, 2018 through July 1, 2018, respectively, as a result of the New Revenue Standard. The reclassified bad debts mentioned above were considered implicit price concessions or contractual revenues under the New Revenue Standard. Remaining bad debts recorded in other operating expenses are related to credit risk or limitations on a customer’s ability to pay.

Cash, cash equivalents and restricted cash

Cash and cash equivalents include highly liquid investments with an original maturity of three months or less when purchased. The Company reclassifies outstanding checks in excess of funds on deposit. As of December 31, 2018, \$20.2 million was reclassified to accounts payable and \$1.5 million was reclassified to salaries, wages and other compensation.

Beginning in 2018, the Company adopted the authoritative guidance that simplifies the disclosure of restricted cash within the statements of cash flows. The following table provides a reconciliation of cash and cash equivalents, as reported in the accompanying consolidated balance sheet, to cash, cash equivalents and restricted cash, as reported in the accompanying consolidated statement of cash flows (in thousands):

	December 31, 2018
Cash and cash equivalents	\$ 84,213
Restricted cash:	
Insurance subsidiary investments (current)	6,951
Other assets (current)	172
Insurance subsidiary investments (long-term)	24,662
Funds in escrow (long-term)	17,158
Cash, cash equivalents and restricted cash	\$ 133,156

Insurance subsidiary investments

The Company maintains a portfolio of insurance subsidiary investments, consisting principally of cash and cash equivalents, for the payment of claims and expenses related to professional liability and workers compensation risks maintained by its limited purpose insurance subsidiary, Cornerstone Insurance Company (“Cornerstone”). These investments are reported at fair value. Since the Company’s insurance subsidiary investments are restricted for a limited purpose, they are classified in the accompanying consolidated balance sheet based upon the expected current and long-term cash requirements of Cornerstone. See Note 8.

Accounts receivable

Accounts receivable consist primarily of amounts due from the Medicare and Medicaid programs, other government programs, managed care health plans, commercial insurance companies, skilled nursing and hospital customers, individual patients and other customers. Estimated provisions for doubtful accounts are recorded to the extent it is probable that a portion or all of a particular account will not be collected.

In evaluating the collectibility of accounts receivable, the Company considers a number of factors, including the age of the accounts, changes in collection patterns, the composition of patient accounts by payor type, the status of ongoing disputes with third party payors and general industry conditions. Actual collections of accounts receivable in subsequent periods may require changes in the estimated provision for loss. Changes in these estimates are charged or credited to the results of operations in the period of change.

The provision for doubtful accounts totaled \$1.2 million for the Successor Company and \$2.1 million for the Predecessor Company.

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Due to third party payors

The Company's TC hospitals and IRFs are required to submit cost reports at least annually to various state and federal agencies administering the respective reimbursement programs. In many instances, interim cash payments to the Company are only an estimate of the amount due for services provided. Any overpayment to the Company arising from the completion of a cost report is recorded as a liability in the accompanying consolidated balance sheet.

Kindred entered into a five-year corporate integrity agreement with the United States Department of Health and Human Services Office of Inspector General (the "OIG") on January 11, 2016 (the "RehabCare CIA"). The RehabCare CIA imposes monitoring, auditing (including by an independent review organization), reporting, certification, oversight, screening, and training obligations with which the Company must comply. These obligations include retention of an independent review organization to perform duties under the RehabCare CIA, which include reviewing compliance by RehabCare Group, Inc. and its subsidiaries ("RehabCare"), a therapy services company acquired by Kindred on June 1, 2011, with federal program requirements and accepted medical practices, and annual reporting obligations to the OIG regarding RehabCare's compliance with the RehabCare CIA (including corresponding certification by senior management and the board of directors or a committee thereof). In the event of a breach of the RehabCare CIA, the Company could become liable for payment of certain stipulated penalties, or RehabCare's subsidiaries could be excluded from participation in federal healthcare programs. The costs associated with compliance with the RehabCare CIA could be substantial and may be greater than the Company currently anticipates.

Any breach or failure to comply with the RehabCare CIA, the imposition of substantial monetary penalties, or any suspension or exclusion from participation in federal healthcare programs, could have a material adverse effect on the Company's business, financial position, results of operations, and liquidity.

Inventories

Inventories consist primarily of pharmaceutical and medical supplies and are stated at the lower of cost (first-in, first-out) or market.

Property and equipment

Property and equipment is carried at cost less accumulated depreciation. Depreciation expense, computed by the straight-line method, was \$28.4 million for the Successor Company and \$36.4 million for the Predecessor Company. These amounts include amortization of assets recorded under capital leases. Depreciation rates for buildings range generally from 20 to 40 years. Leasehold improvements are depreciated over their estimated useful lives or the remaining lease term, whichever is shorter. Estimated useful lives of equipment vary from five to 15 years. Depreciation expense is not recorded for property and equipment classified as held for sale. Repairs and maintenance are expensed as incurred.

The Company separates capital expenditures into two categories, routine and development, in the accompanying consolidated statements of cash flows. Purchases of routine property and equipment include expenditures at existing facilities that generally do not result in increased capacity or the expansion of services. Development capital expenditures include expenditures for the development of new facilities or the expansion of services or capacity at existing facilities.

Long-lived assets

The Company reviews the carrying value of certain long-lived assets and finite lived intangible assets with respect to any events or circumstances that indicate an impairment or an adjustment to the amortization period is necessary. If circumstances suggest that the recorded amounts cannot be recovered based upon estimated future undiscounted cash flows, the carrying values of such assets are reduced to fair value.

In assessing the carrying values of long-lived assets, the Company estimates future cash flows at the lowest level for which there are independent, identifiable cash flows. For this purpose, these cash flows are aggregated based upon the contractual agreements underlying the operation of the facility or group of facilities. Generally, an individual facility for hospitals or IRFs, skilled nursing rehabilitation services reporting unit, or hospital rehabilitation services reporting unit are considered the lowest level for which there are independent, identifiable cash flows. However, to the extent that groups of facilities are leased under a master lease agreement in which the operations of a facility and compliance with the lease terms are interdependent upon other facilities in the agreement (including the Company's ability to renew the lease or divest a particular property), the Company defines the group of facilities under a master lease agreement, or a renewal bundle in a master lease, as the lowest level for which there are independent, identifiable cash flows. Accordingly, the estimated cash flows of all facilities within a master lease agreement, or within a renewal bundle in a master lease, are aggregated for purposes of evaluating the carrying values of long-lived assets.

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Goodwill and intangible assets

Goodwill and indefinite-lived intangible assets primarily originated from business combinations accounted for as purchase transactions or from the Kindred Reorganization.

A summary of goodwill by reporting unit follows (in thousands):

	<u>Hospitals</u>	<u>Accountable Care Organization</u>	<u>Hospital rehabilitation services</u>	<u>IRFs</u>	<u>RehabCare</u>	<u>Total</u>
Balances, December 31, 2017	\$ 125,045	\$ 983	\$ 173,618	\$ 326,335	\$ –	\$ 625,981
Acquisitions	–	–	–	10,375	–	10,375
Balances, July 1, 2018	<u>125,045</u>	<u>983</u>	<u>173,618</u>	<u>336,710</u>	<u>–</u>	<u>636,356</u>
Balances, July 2, 2018	125,045	983	173,618	336,710	–	636,356
Kindred Reorganization purchase accounting adjustments	<u>(125,045)</u>	<u>(983)</u>	<u>(58,681)</u>	<u>(130,684)</u>	<u>–</u>	<u>(315,393)</u>
Balances, December 31, 2018	<u>\$ –</u>	<u>\$ –</u>	<u>\$ 114,937</u>	<u>\$ 206,026</u>	<u>\$ –</u>	<u>\$ 320,963</u>

Accumulated goodwill impairment charges as of July 1, 2018 (the Predecessor Company) were \$651.3 million. There were no accumulated goodwill impairment charges as of December 31, 2018 (the Successor Company).

In accordance with the authoritative guidance for goodwill and other intangible assets, the Company is required to perform an impairment test for goodwill and indefinite-lived intangible assets at least annually or more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. The Company performs its annual goodwill impairment test on October 1 each fiscal year for each of its reporting units.

A reporting unit is either an operating segment or one level below the operating segment, referred to as a component. When the components within the Company's operating segments have similar economic characteristics, the Company aggregates the components of its operating segments into one reporting unit. Accordingly, the Company has determined that its reporting units are hospitals, the Accountable Care Organization, hospital rehabilitation services, IRFs, and RehabCare.

Accounting guidance allows the Company to perform a qualitative assessment about the likelihood of the carrying value of a reporting unit exceeding its fair value, referred to as the step zero assessment. The step zero assessment requires the evaluation of certain qualitative factors, including macroeconomic conditions, industry and market considerations, cost factors and overall financial performance, as well as company and reporting unit factors. If the Company's step zero assessment indicates that it is more likely than not that the fair value of a reporting unit is less than the carrying value amount, then the Company would perform a quantitative impairment test. The Company applied the step zero assessment to its two reporting units with goodwill as of October 1. The Company's step zero assessment concluded that it is not more likely than not that the fair value of the reporting unit is less than its carrying value amount. Therefore, a quantitative goodwill impairment test for these reporting units was not required.

Adverse changes in the operating environment and related key assumptions used to determine the fair value of the Company's reporting units and indefinite-lived intangible assets may result in future impairment charges for a portion or all of these assets. Specifically, if the rate of growth of government and commercial revenues earned by the Company's reporting units were to be less than projected, if healthcare reforms were to negatively impact the Company's business, or if recent increases in labor costs materially exceed the Company's projections in its reporting units or business segments, an impairment charge of a portion or all of these assets may be required. An impairment charge could have a material adverse effect on the Company's business, financial position and results of operations, but would not be expected to have an impact on the Company's cash flows or liquidity.

The Company's indefinite-lived intangible assets consist of a trade name, Medicare certifications, and certificates of need. The fair values of the Company's indefinite-lived intangible assets are derived from current market data such as royalty rates and projections at a facility or reporting unit, which include management's best estimates of economic and market conditions over the projected period. Significant assumptions include projected revenues, operating costs, rent expense, capital expenditures, terminal value growth rates, changes in working capital requirements, weighted average cost of capital and opportunity costs.

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Goodwill and intangible assets (Continued)

The Company performs its annual indefinite-lived intangible asset impairment tests on October 1 each fiscal year. The Company elected a step zero assessment for the October 1, 2018 impairment review. Based upon the results of the annual impairment test for indefinite-lived intangible assets discussed above for the year ended December 31, 2018, no impairment charges were recorded.

The Company's intangible assets include both finite and indefinite-lived intangible assets. The Company's intangible assets with finite lives are amortized in accordance with the authoritative guidance for goodwill and other intangible assets, such as leasehold interest assets and non-compete agreements, using the straight-line method over their estimated useful lives ranging from one to 38 years.

The amortization of leasehold interests is recorded as a component of building rent expense..

Amortization expense computed by the straight-line method totaled \$4.4 million for the Successor Company and \$4.3 million for the Predecessor Company.

The estimated annual amortization expense for the next five years for intangible assets at December 31, 2018 follows (in thousands):

2019	\$	5,579
2020	\$	1,240
2021	\$	–
2022	\$	–
2023	\$	–

A summary of intangible assets at December 31, 2018 follows (in thousands):

	<u>Cost</u>	<u>Accumulated amortization</u>	<u>Carrying value</u>	<u>Weighted average life</u>
Non-current:				
Certificates of need (indefinite life)	\$ 38,000	\$ –	\$ 38,000	
Medicare certifications (indefinite life)	29,100	–	29,100	
Trade name (indefinite life)	28,000	–	28,000	
Leasehold interest assets	109,115	(11,129)	97,986	8 years
Non-compete agreements	11,159	(4,340)	6,819	1 year
	<u>\$ 215,374</u>	<u>\$ (15,469)</u>	<u>\$ 199,905</u>	

Cost-method investments

The aggregate carrying amount of all cost-method investments was \$15.0 million as of December 31, 2018. Each investment was evaluated for impairment as of December 31, 2018 and no impairment charges were recorded.

Insurance risks

Provisions for loss for professional liability and workers compensation risks are based upon management's best available information, including actuarially determined estimates of loss. To the extent that expected ultimate claims costs vary from historical provisions for loss, future earnings will be charged or credited. See Note 7.

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Derivative financial instruments

The Company accounts for derivative financial instruments in accordance with the authoritative guidance for derivatives and hedging. These derivative financial instruments are recognized as assets or liabilities in the accompanying consolidated balance sheet and are measured at fair value. The Company's derivatives are designated as cash flow hedges. The Company entered into an interest rate swap agreement in October 2018 to hedge its floating interest rate risk. Kindred previously had three interest rate swap agreements that were settled in June 2018.

The interest rate swap was assessed for hedge effectiveness for accounting purposes and the Company determined the interest rate swap qualifies for cash flow hedge accounting treatment at December 31, 2018. The Company uses the private company simplified hedge accounting standard and records the effective portion of the gain or loss on derivative financial instruments in accumulated other comprehensive income (loss) as a component of members' equity and records the ineffective portion of the gain or loss on derivative financial instruments as interest expense. There was no ineffectiveness related to the interest rate swap for the Successor Company. See Note 10.

Variable interest entities

The Company follows the provisions of the authoritative guidance for determining whether an entity is a VIE. In order to determine if the Company is a primary beneficiary of a VIE for financial reporting purposes, it must consider whether it has the power to direct activities of the VIE that most significantly impact the performance of the VIE and whether the Company has the obligation to absorb losses or the right to receive returns that would be significant to the VIE. The Company consolidates a VIE when it is the primary beneficiary.

Of the Company's 22 operating IRFs as of December 31, 2018, 20 are partnerships subject to an operating and management services agreement. Under GAAP, the Company determined that 17 of these 20 partnerships qualify as VIEs and concluded that the Company is the primary beneficiary in all but one partnership. The Company holds an ownership interest and acts as manager in each of the partnerships. Through the management services agreement, the Company is delegated necessary responsibilities to provide management services, administrative services and direction of the day-to-day operations. Based upon the Company's assessment of the most significant activities of the IRFs, the manager has the ability to direct the majority of those activities in 16 of these partnerships.

The analysis upon which the consolidation determination rests can be complex, can involve uncertainties, and requires judgment on various matters, some of which could be subject to different interpretations.

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 – BASIS OF PRESENTATION (Continued)

Variable interest entities (Continued)

The carrying amounts and classifications of the assets and liabilities of the consolidated VIEs are as follows (in thousands):

	Successor Company
	December 31, 2018
Assets:	
Current assets:	
Cash and cash equivalents	\$ 49,139
Accounts receivable, net	47,201
Inventories	1,862
Other	3,534
	101,736
Property and equipment, net	21,570
Goodwill	177,274
Intangible assets, net	74,614
Other	6
Total assets	\$ 375,200
Liabilities:	
Current liabilities:	
Accounts payable	\$ 25,457
Salaries, wages and other compensation	4,477
Other accrued liabilities	5,578
Long-term debt due within one year	359
	35,871
Long-term debt	21
Deferred credits and other liabilities	10,541
Total liabilities	\$ 46,433

Allocated expense

Amounts were allocated from the Predecessor Company for costs attributable to the operations of KAH. The expenses incurred by the Predecessor Company include costs from certain support center and shared service functions provided by the Predecessor Company to KAH.

All support center costs of the Predecessor Company that were specifically identifiable to KAH have been allocated to KAH. Where specific identification of charges to KAH was not practicable, a percentage of revenues method was applied to all remaining general support center overhead costs. These costs include overhead expenses such as accounting, cash management, cost reimbursement reporting, human resources, legal, executive management, marketing and software and information technology.

In the opinion of management, the cost allocations have been determined on a reasonable basis and include all the costs of doing business. The amounts that would have been or will be incurred on a stand-alone basis could differ from the amounts allocated due to economies of scale, management judgment, or other factors. See Note 17 for additional information regarding related party transactions.

Other information

The Successor Company and the Predecessor Company both performed evaluations of subsequent events through the date on which the accompanying consolidated financial statements were issued.

NOTE 2 – ACQUISITION OF KINDRED

Merger Agreement

On July 2, 2018, Kindred was acquired by a consortium of TPG, WCAS and Humana. Subject to the terms and conditions of an Agreement and Plan of Merger (the “Merger Agreement”) among Kindred, Kentucky Hospital Holdings, LLC (“HospitalCo Parent”), Kentucky Homecare Holdings, Inc. (“Parent”) and Kentucky Homecare Merger Sub, Inc. (“Merger Sub”), Merger Sub was merged with and into Kindred (the “Merger”), with Kindred continuing as the surviving company in the Merger.

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 2 – ACQUISITION OF KINDRED (Continued)

Merger Agreement (Continued)

At the effective time of the Merger, each share of Kindred common stock, par value \$0.25 per share (“Common Stock”) issued and outstanding immediately prior to the effective time of the Merger (other than shares held by Parent, HospitalCo Parent, Merger Sub or Kindred and their respective wholly owned subsidiaries (which were cancelled) and shares that are owned by stockholders who properly exercised and perfected a demand for appraisal rights under Delaware law), were cancelled and converted into the right to receive \$9.00 in cash, without interest (the “Merger Consideration”). See Note 16.

Separation Agreement

Concurrently with the execution and delivery of the Merger Agreement, on December 19, 2017, Kindred, Parent, HospitalCo Parent, and Kentucky Hospital Merger Sub, Inc., entered into a Separation Agreement (the “Separation Agreement”), pursuant to which, promptly following the effective time of the Merger, Kindred was separated from its former home health, hospice and community care services business and acquired by HospitalCo Parent.

The Separation Agreement relates to, among other things (i) certain restructuring transactions that took place with respect to Kindred and its subsidiaries, (ii) procedures concerning the transfer of certain assets and employees used or employed in Kindred’s respective businesses and (iii) the allocation of costs and expenses related to the separation of Kindred from KAH.

Purchase price allocation

The Merger purchase price of \$219.9 million was allocated on a preliminary basis based upon the estimated fair value of the tangible and intangible assets, and goodwill.

The following is the preliminary Merger purchase price allocation (in thousands):

Cash and cash equivalents	\$	141,030
Accounts receivable		737,972
Inventories		20,922
Income taxes		2,657
Assets held for sale		9,546
Other current assets		224,213
Property and equipment		582,113
Identifiable intangible assets:		
Certificates of need (indefinite life)	\$	38,000
Medicare certifications (indefinite life)		29,100
Trade name (indefinite life)		28,000
Leasehold interest assets		109,115
Non-compete agreements		11,159
Total identifiable intangible assets		<u>215,374</u>
Insurance subsidiary investments		22,308
Other long-term assets		228,827
Accounts payable		(132,229)
Salaries, wages and other compensation		(210,085)
Due to third party payors		(18,369)
Professional liability risks, current portion		(43,898)
Other accrued liabilities		(368,650)
Current portion of long-term debt		(3,390)
Long-term debt, less current portion		(493,026)
Professional liability risks, long-term portion		(238,992)
Leasehold interest liabilities		(268,800)
Other long-term liabilities		(313,530)
Noncontrolling interests		(195,060)
Total identifiable net assets		<u>(101,067)</u>
Goodwill		320,963
Net assets	\$	<u>219,896</u>

The fair value allocation was measured primarily using a discounted cash flows methodology, which is considered a Level 3 input (as described in Note 15).

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 3 – DIVESTITURES

Discontinued operations

Skilled nursing facility business exit

On June 30, 2017, Kindred entered into a definitive agreement with BM Eagle Holdings, LLC, a joint venture led by affiliates of BlueMountain Capital Management, LLC (“BlueMountain”), under which Kindred agreed to sell its skilled nursing facility business for \$700 million in cash (the “SNF Divestiture”). The SNF Divestiture included 89 nursing centers with 11,308 licensed beds and seven assisted living facilities with 380 licensed beds in 18 states. Through July 1, 2018, the Predecessor Company completed the sale or closed 86 of the skilled nursing facilities and all seven of the assisted living facilities on various dates. The Successor Company completed the sale of the remaining three skilled nursing facilities between July 2, 2018 and December 31, 2018.

In accordance with authoritative guidance for assets held for sale and discontinued operations accounting, the skilled nursing facility business is reported as assets held for sale and was moved to discontinued operations for all periods presented.

In connection with the SNF Divestiture, Kindred entered into an interim management agreement in the third quarter of 2017 with certain affiliates of BlueMountain in the state of California whereby Kindred would lease its license of certain operations to such affiliates until licensure approval is obtained. Because the Company has continuing involvement in the business through purveying certain rights of ownership of the assets while under the interim management agreement and license sublease, the Company did not meet the requirements for a sale-leaseback transaction as described in ASC 840-40, *Leases - Sale-Leaseback Transactions*. Under the failed-sale-leaseback accounting model, the Company is deemed under GAAP to still own certain real estate assets sold to BlueMountain, which the Company must continue to reflect in its consolidated balance sheet as assets held for sale. The Company also must treat a portion of the pretax cash proceeds from the SNF Divestiture as though it were the result of a \$53.1 million other current liability financing obligation in the Company’s accompanying consolidated balance sheet until continuing involvement ceases. The lease will terminate upon licensure approval, at which time the Company will cease to recognize the remaining other current liability financing obligation, as well as the remaining net book value of the real estate assets.

During 2018, the Successor Company recorded \$5.8 million of pretax charges related to the SNF Divestiture consisting of transaction and other costs. During 2018, the Predecessor Company recorded \$7.9 million of pretax charges related to the SNF Divestiture, including \$5.2 million of transaction and other costs and \$2.7 million of retention costs.

NOTE 4 – DISCONTINUED OPERATIONS

In accordance with the authoritative guidance for the impairment or disposal of long-lived assets, the divestiture of unprofitable businesses has been accounted for as discontinued operations. Accordingly, the results of operations of these businesses for all periods presented and the losses related to these divestitures have been classified as discontinued operations, net of income taxes, in the accompanying consolidated statement of operations and accompanying combined statement of operations.

The following table summarizes (in thousands) the SNF Divestiture liability activity (included in current liabilities):

	<u>Retention</u>	<u>Transaction and other costs</u>	<u>Total</u>
Liability balance at December 31, 2017	\$ 5,436	\$ 5,600	\$ 11,036
Expense	2,686	1,303	3,989
Payments	<u>(4,400)</u>	<u>(4,468)</u>	<u>(8,868)</u>
Liability balance at July 1, 2018	3,722	2,435	6,157
<hr/>			
Liability balance at July 2, 2018	3,722	2,435	6,157
Expense	–	6,042	6,042
Payments	<u>(2,199)</u>	<u>(3,064)</u>	<u>(5,263)</u>
Liability balance at December 31, 2018	<u>\$ 1,523</u>	<u>\$ 5,413</u>	<u>\$ 6,936</u>

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 4 – DISCONTINUED OPERATIONS (Continued)

A summary of discontinued operations follows (in thousands):

	Successor Company	Predecessor Company
	July 2 – December 31, 2018	January 1 – July 1, 2018
Revenues	\$ 4,482	\$ 13,378
Salaries, wages and benefits	1,250	9,358
Supplies	23	521
Building rent	1,066	2,435
Equipment rent	16	41
Other income	(5,041)	(2,560)
Depreciation and amortization	–	3,397
Interest expense	–	2
Investment income	(49)	(61)
	<u>(2,735)</u>	<u>13,133</u>
Income from operations before income taxes	7,217	245
Provision for income taxes	–	–
Income from operations	7,217	245
Loss on divestiture of operations	(5,830)	(7,893)
Income (loss) from discontinued operations	1,387	(7,648)
Earnings attributable to noncontrolling interests	(80)	(700)
Income (loss) attributable to Kindred	<u>\$ 1,307</u>	<u>\$ (8,348)</u>

Net assets held for sale at December 31, 2018 consists of \$53.1 million in net book value of real estate assets related to five sale-leaseback transactions. See Note 3.

NOTE 5 – RESTRUCTURING CHARGES

The Company has initiated various restructuring activities whereby it has incurred costs associated with reorganizing its operations, including the divestiture, closure of facilities, reduced headcount and realigned operations in order to improve operations, cost efficiencies and capital structure in response to changes in the healthcare industry, increasing leverage and to partially mitigate reductions in reimbursement rates from third party payors. The costs associated with these activities are reported as restructuring charges in the accompanying consolidated statement of operations and accompanying combined statement of operations and would have been recorded as salaries, wages and benefits, other operating expenses or rent expense if not classified as restructuring charges.

The following table sets forth the restructuring charges incurred by restructuring activities (in thousands):

	Successor Company	Predecessor Company
	July 2 – December 31, 2018	January 1 – July 1, 2018
Acquisition of Kindred	\$ 52,645	\$ 9,484
LTAC Hospital Portfolio Repositioning 2017 Plan	880	1,089
LTAC Hospital Portfolio Repositioning 2016 Plan	1,536	1,251
Other various	290	–
	<u>\$ 55,351</u>	<u>\$ 11,824</u>

Restructuring Activities

Acquisition of Kindred

During 2017, Kindred announced that the board had approved the Merger Agreement as described in Note 2. The costs incurred in 2018 related to the Merger Agreement include retention, severance and merger costs and are expected to be substantially completed in 2019.

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 5 – RESTRUCTURING CHARGES (Continued)

Restructuring Activities (Continued)

Acquisition of Kindred (Continued)

The composition of the restructuring costs that the Company has incurred for these restructuring initiatives is as follows (in thousands):

	<u>Successor Company</u> <u>July 2 – December 31, 2018</u>	<u>Predecessor Company</u> <u>January 1 – July 1, 2018</u>
Retention and severance costs	\$ 45,118	\$ 2,422
Merger costs	7,527	7,062
	<u>\$ 52,645</u>	<u>\$ 9,484</u>

The following table (in thousands) summarizes the Merger restructuring liability activity (included in other accrued liabilities):

	<u>Retention and severance costs</u>	<u>Merger costs</u>	<u>Total</u>
Liability balance at December 31, 2017	\$ –	\$ 7,907	\$ 7,907
Expense	2,422	7,062	9,484
Payments	<u>(406)</u>	<u>(6,043)</u>	<u>(6,449)</u>
Liability balance at July 1, 2018	2,016	8,926	10,942
<hr/>			
Liability balance at July 2, 2018	2,016	8,926	10,942
Expense	45,118	7,527	52,645
Payments	<u>(37,757)</u>	<u>(15,026)</u>	<u>(52,783)</u>
Liability balance at December 31, 2018	<u>\$ 9,377</u>	<u>\$ 1,427</u>	<u>\$ 10,804</u>

LTAC Hospital Portfolio Repositioning 2017 Plan

During 2017, Kindred approved phase two of the LTAC hospital portfolio repositioning plan that incorporated the closure and conversion of certain LTAC hospitals as part of its mitigation strategies in response to new patient criteria for LTAC hospitals. The activities related to the LTAC hospital portfolio repositioning 2017 plan were substantially completed by the end of 2018, except for the lease termination liability and related costs which will extend through 2025.

The composition of the restructuring charges that the Company has incurred for these activities is as follows (in thousands):

	<u>Successor Company</u> <u>July 2 – December 31, 2018</u>	<u>Predecessor Company</u> <u>January 1 – July 1, 2018</u>
Lease termination costs	\$ 844	\$ 938
(Gain) loss on disposal	36	(424)
Asset write-offs	–	418
Severance	–	157
	<u>\$ 880</u>	<u>\$ 1,089</u>

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 5 – RESTRUCTURING CHARGES (Continued)

Restructuring Activities (Continued)

LTAC Hospital Portfolio Repositioning 2017 Plan (Continued)

The following table (in thousands) summarizes the Company’s LTAC hospital portfolio repositioning 2017 plan liability activity (included in current liabilities and deferred credits and other liabilities) during the year ended December 31, 2018:

	Lease termination costs
Liability balance at December 31, 2017	\$ 31,645
Expense	938
Payments	(2,519)
Liability balance at July 1, 2018	30,064
<hr/>	
Liability balance at July 2, 2018	30,064
Expense	844
Payments	(2,567)
Liability balance at December 31, 2018	\$ 28,341

LTAC Hospital Portfolio Repositioning 2016 Plan

During 2016, Kindred approved the LTAC hospital portfolio repositioning 2016 plan that incorporated the divestiture, swap or closure of certain LTAC hospitals as part of its mitigation strategies to prepare for new patient criteria for LTAC hospitals. The activities related to the LTAC hospital portfolio repositioning 2016 plan were substantially completed during 2016, except for the lease termination liability and related costs which will extend through 2025.

The composition of the restructuring charges that the Company has incurred for these activities is as follows (in thousands):

	Successor Company	Predecessor Company
	July 2 – December 31, 2018	January 1 – July 1, 2018
Lease termination costs	\$ 1,536	\$ 1,251

The following table (in thousands) summarizes the Company’s LTAC hospital portfolio repositioning 2016 plan liability activity (included in current liabilities and deferred credits and other liabilities) during the year ended December 31, 2018:

	Lease termination costs
Liability balance at December 31, 2017	\$ 33,945
Expense	1,251
Payments	(5,236)
Liability balance at July 1, 2018	29,960
<hr/>	
Liability balance at July 2, 2018	29,960
Expense	1,536
Payments	(6,212)
Liability balance at December 31, 2018	\$ 25,284

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 6 – INCOME TAXES

Provision for income taxes consists of the following (in thousands):

	<u>Successor Company</u> July 2 – December 31, 2018	<u>Predecessor Company</u> January 1 – July 1, 2018
Current:		
Federal	\$ 427	\$ –
State	81	1,112
	<u>508</u>	<u>1,112</u>
Deferred	58	654
	<u>\$ 566</u>	<u>\$ 1,766</u>

Reconciliation of federal statutory tax expense (income) to the provision for income taxes follows (in thousands):

	<u>Successor Company</u> July 2 – December 31, 2018	<u>Predecessor Company</u> January 1 – July 1, 2018
Income tax expense (benefit) at federal rate	\$ 480	\$ (10,444)
State income tax expense (benefit), net of federal income tax benefit	86	(1,989)
Gain on sale of partnership interest	–	6,164
Valuation allowance	–	(11,842)
Noncontrolling interests	–	(5,476)
Interest expense disallowance	–	20,037
Federal and state tax credits	–	(320)
Transaction costs	–	4,517
Other items, net	–	1,119
	<u>\$ 566</u>	<u>\$ 1,766</u>

Other items consist of meals, entertainment, lobbying, and other permanent differences, which individually are deemed immaterial.

Predecessor Company

The Tax Cuts and Jobs Act of 2017, which was enacted on December 22, 2017, was generally effective in 2018 and made broad and significantly complex changes to the federal corporate tax system, including the reduction in the U.S. federal corporate income tax rate from 35% to 21% and the limitation on the deductibility of interest expense.

At each balance sheet date, management assesses all available positive and negative evidence to determine whether a valuation allowance is needed against its deferred tax assets. The authoritative guidance requires evidence related to events that have actually happened to be weighted more significantly than evidence that is projected or expected to happen. A significant piece of negative evidence according to this weighting standard is if there are cumulative losses in the two most recent years and the current year, which was the case for Kindred at July 1, 2018. Accordingly, a full valuation allowance was recorded at July 1, 2018. The amount of deferred tax asset considered realizable, however, could be adjusted if the weighting of the positive and negative evidence changes.

The Predecessor Company followed the provisions of the authoritative guidance for accounting for uncertainty in income taxes which clarified the accounting for uncertain income tax issues recognized in an entity's financial statements. The guidance prescribed a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in an income tax return.

The Predecessor Company recorded accrued interest and penalties associated with uncertain tax positions as income tax expense in the accompanying combined statement of operations. The Predecessor Company did not have any reserves for uncertain income taxes at July 1, 2018.

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 6 – INCOME TAXES (Continued)

Predecessor Company (Continued)

The federal statute of limitations remains open for tax years 2015 through 2017 for the Predecessor Company . During 2018, the Company resolved the federal income tax audits for the 2016 tax year for the Predecessor Company . The Company is currently under examination by the Internal Revenue Service for the Predecessor Company for the 2017 tax year and for the tax year ending July 1, 2018.

State jurisdictions generally have statutes of limitations for tax returns ranging from three to five years. The state impact of federal income tax changes remains subject to examination by various states for a period of up to one year after formal notification to the states. Currently, the Company has various state income tax returns under examination for the Predecessor Company.

Successor Company

Following the Kindred Reorganization and separation, Kindred Healthcare, LLC was a disregarded entity of HospitalCo Parent. HospitalCo Parent was taxed as a C Corporation from the separation date through August 1, 2018. On August 1, 2018, HospitalCo Parent was converted to a single member limited liability company (the “Conversion”) wholly owned by Kentucky Hospital Holdings JV, L.P., (“Hospital JV”), an entity taxed as a partnership for U.S. federal income tax purposes. There was no tax due or refundable on the HospitalCo Parent C Corporation return and the net operating loss generated in that one month was eliminated following the Conversion. Immediately following the Conversion, Kindred Healthcare, LLC became a disregarded entity of Hospital JV so it is effectively treated as a partnership for federal income tax purposes from August 2, 2018 through December 31, 2018. As such, federal and state taxable income or loss generally passes through to the individual partners for inclusion in their respective income tax returns.

The federal current tax expense from the Successor Company shown above was mainly generated by Cornerstone, which is a wholly owned C Corporation required to file a separate federal income tax return.

NOTE 7 – INSURANCE RISKS

On a per-claim basis, the Company maintains a self-insured retention and Cornerstone insures all losses in excess of this retention. Cornerstone maintains commercial reinsurance through unaffiliated commercial reinsurers for these losses in excess of the Company’s retention. On a per-claim basis, the Company maintains a deductible under commercial insurance policies for workers compensation which provide coverage up to statutory limits in each state. The provisions for loss for professional liability and workers compensation risks are based upon management’s best available information, including actuarially determined estimates of loss.

The allowance for professional liability risks includes an estimate of the expected cost to settle reported claims and an amount, based upon past experiences, for losses incurred but not reported including claims related to the nursing centers prior to the SNF Divestiture. These liabilities are necessarily based upon estimates and, while management believes that the provision for loss is adequate, the ultimate liability may be in excess of, or less than, the amounts recorded. To the extent that expected ultimate claims costs vary from historical provisions for loss, future earnings will be charged or credited.

The provision for loss for insurance risks, including the cost of coverage maintained with unaffiliated commercial reinsurance and insurance carriers, follows (in thousands):

	<u>Successor Company</u> July 2 – December 31, 2018	<u>Predecessor Company</u> January 1 – July 1, 2018
Professional liability:		
Continuing operations	\$ 16,118	\$ 16,999
Discontinued operations	(3,626)	(5,191)
Workers compensation:		
Continuing operations	\$ 4,067	\$ 4,174
Discontinued operations	(622)	(1,875)

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 7 – INSURANCE RISKS (Continued)

A summary of the assets and liabilities related to insurance risks included in the accompanying consolidated balance sheet at December 31, 2018 follows (in thousands):

	Successor Company		
	December 31, 2018		
	Professional liability	Workers compensation	Total
Assets:			
Current:			
Insurance subsidiary investments	\$ 6,511	\$ 440	\$ 6,951
Reinsurance and other recoverables	286	1,447	1,733
Other	–	50	50
	<u>6,797</u>	<u>1,937</u>	<u>8,734</u>
Non-current:			
Insurance subsidiary investments	9,791	14,871	24,662
Reinsurance and other recoverables	97,515	51,208	148,723
Deposits	–	1,514	1,514
	<u>107,306</u>	<u>67,593</u>	<u>174,899</u>
	<u>\$ 114,103</u>	<u>\$ 69,530</u>	<u>\$ 183,633</u>
Liabilities:			
Allowance for insurance risks:			
Current	\$ 41,205	\$ 13,475	\$ 54,680
Non-current	233,732	78,418	312,150
	<u>\$ 274,937</u>	<u>\$ 91,893</u>	<u>\$ 366,830</u>

The provision for loss for professional liability risks is not funded to Cornerstone. The Company does not fund the portion of professional liability risks related to estimated claims that have been incurred but not reported.

The provision for loss for workers compensation risks is not funded to Cornerstone.

NOTE 8 – INSURANCE SUBSIDIARY INVESTMENTS

The Company maintains a portfolio of insurance subsidiary investments, consisting principally of cash and cash equivalents, for the payment of claims and expenses related to professional liability and workers compensation risks maintained by Cornerstone. These investments are reported at fair value. Since the Company's insurance subsidiary investments are restricted for a limited purpose, they are classified in the accompanying consolidated balance sheet based upon the expected current and long-term cash requirements of Cornerstone.

The Company's insurance subsidiary cash and cash equivalents were \$31.6 million at December 31, 2018.

Investment income earned by Cornerstone approximated \$0.1 million for both the Successor Company and the Predecessor Company.

NOTE 9 – LEASES

Various facility leases include contingent annual rent escalators based upon a change in the Consumer Price Index or other agreed upon terms such as a patient revenue test. These contingent rents are included in building rent expense in the time period incurred. The Successor Company recorded contingent rent of \$1.0 million and the Predecessor Company recorded contingent rent of \$0.3 million, including both continuing operations and discontinued operations.

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 9 – LEASES (Continued)

Future minimum payments under non-cancelable operating leases are as follows (in thousands):

	Minimum payments		
	Ventas	Other	Total
2019	\$ 112,857	\$ 89,650	\$ 202,507
2020	113,761	83,792	197,553
2021	114,687	78,551	193,238
2022	115,637	71,128	186,765
2023	99,354	70,338	169,692
Thereafter	122,410	295,097	417,507

Ventas master lease agreements

At December 31, 2018, the Company leased from Ventas, Inc. (“Ventas”) and its affiliates 29 TC hospitals under one master lease agreement (the “Master Lease Agreement”). The Master Lease Agreement includes land, buildings, structures, and other improvements on the land, easements, and similar appurtenances to the land and improvements, and permanently affixed equipment, machinery, and other fixtures relating to the operation of the leased properties. There are two bundles of leased properties under the Master Lease Agreement, with each bundle containing several TC hospitals.

Recent master lease amendments

On March 27, 2018, Kindred and Ventas entered into an Amendment No. 3 to the Master Lease Agreement pursuant to which rents were reallocated among the 29 Ventas properties.

Rental amounts and escalators

The Master Lease Agreement is commonly known as a triple-net lease or an absolute-net lease. Accordingly, in addition to rent, the Company is required to pay the following: (1) all insurance required in connection with the leased properties and the business conducted on the leased properties, (2) certain taxes levied on or with respect to the leased properties (other than taxes on the income of Ventas), and (3) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties.

The Successor Company and the Predecessor Company paid rents to Ventas (including amounts classified within discontinued operations) of approximately \$61.7 million and \$60.7 million, respectively, in 2018.

The Master Lease Agreement provides for rent escalations each May 1. All annual rent escalators are payable in cash. The contingent annual rent escalator for the Master Lease Agreement is based upon annual increases in the Consumer Price Index, subject to a ceiling of 4%. In 2018, the contingent annual rent escalator was 2.21% for the Master Lease Agreement.

NOTE 10 – LONG-TERM DEBT

Capitalization

A summary of long-term debt at December 31, 2018 follows (in thousands):

	2018
Term Loan Facility, net of unamortized original issue discount of \$3.8 million	\$ 405,168
ABL Facility	64,300
Other	380
Debt issuance costs, net of accumulated amortization	(9,655)
Total debt, average life of 6 years (weighted average rate 7.8%)	460,193
Amounts due within one year	(4,433)
Long-term debt	\$ 455,760

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 10 – LONG-TERM DEBT (Continued)

Capitalization (Continued)

The following table summarizes scheduled maturities of long-term debt (in thousands):

	Term Loan Facility	ABL Facility	Other	Total
2019	\$ 4,074	\$ –	\$ 359	\$ 4,433
2020	4,034	–	21	4,055
2021	3,994	–	–	3,994
2022	3,954	–	–	3,954
2023	3,914	64,300	–	68,214
Thereafter	389,005	–	–	389,005
	<u>\$ 408,975</u>	<u>\$ 64,300</u>	<u>\$ 380</u>	<u>\$ 473,655</u>

The estimated fair value of the Company’s long-term debt approximated \$444.9 million at December 31, 2018. See Note 15.

Credit Facilities

As used herein, the “Credit Facilities” refers collectively to the Term Loan Facility and the ABL Facility, in each case as defined and described below.

Term Loan Facility

The “Term Loan Facility” refers to the Company’s \$410 million term loan credit facility provided pursuant to the terms and provisions of that certain Term Loan Credit Agreement dated as of July 2, 2018 (the “Term Loan Credit Agreement”), among the Company, the lenders from time to time party thereto, and JPMorgan Chase Bank, N.A., as administrative agent and collateral agent. All obligations under the Term Loan Facility are fully and unconditionally guaranteed, subject to certain customary release provisions, by substantially all of the Company’s wholly owned, domestic material subsidiaries (subject to certain designated exceptions), as well as the Company’s immediate parent entity, plus any foreign or non-wholly owned domestic subsidiaries that the Company may determine from time to time in its sole discretion (collectively, the “Guarantors”). The obligations under the Term Loan Facility are secured by substantially all of the assets of the Company and the Guarantors.

The Term Loan Facility (1) matures on July 2, 2025, (2) amortizes annually at 1.00%, payable in quarterly installments commencing on December 31, 2018, (3) imposes a variety of restrictions including restrictions on the Company’s ability to incur debt and liens and make acquisitions, investments and payments on equity and junior debt, and (4) provides for interest rate margins of 5.00% for LIBOR borrowings and 4.00% for base rate borrowings. The Term Loan Facility contains no financial maintenance covenants.

ABL Facility

The “ABL Facility” refers to the Company’s \$450 million asset-based loan revolving credit facility provided pursuant to the terms and provisions of that certain ABL Credit Agreement dated as of July 2, 2018 (the “ABL Credit Agreement”) among the Company, the lenders party thereto from time to time, and JPMorgan Chase Bank, N.A., as administrative agent and collateral agent. All obligations under the ABL Facility are fully and unconditionally guaranteed, subject to certain customary release provisions, by substantially all of the Company’s wholly owned, domestic material subsidiaries (subject to certain designated exceptions), as well as the Company’s immediate parent entity, plus any foreign or non-wholly owned domestic subsidiaries that the Company may determine from time to time in its sole discretion. The obligations under the ABL Facility are secured by substantially the same collateral as the obligations under the Term Loan Facility. As of December 31, 2018, \$61.2 million of letters of credit were outstanding under the ABL Facility.

The ABL Facility (1) matures on July 2, 2023, (2) contains a financial maintenance covenant in the form of a springing minimum fixed charge coverage ratio, (3) imposes a variety of restrictions including restrictions on the Company’s ability to incur debt and liens and make acquisitions, investments and payments on equity and junior debt, particularly if the payment condition is not satisfied and (4) provides for interest rate margins of 2.00% to 2.50% for LIBOR borrowings and 1.00% to 1.50% for base rate borrowings (in each case depending on average daily excess availability), and (5) employs a borrowing base calculation to determine total available capacity thereunder.

The Company was in compliance with the terms of the Credit Facilities at December 31, 2018.

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 10 – LONG-TERM DEBT (Continued)

Interest rate swap

In October 2018, the Company entered into an interest rate swap agreement to hedge its floating interest rate on \$250 million of outstanding Term Loan Facility debt. The interest rate swap has an effective date of September 30, 2018, and expires on September 30, 2023. The Company is required to make payments based upon a fixed interest rate of 3.1079% calculated on the notional amount of \$250 million. In exchange, the Company will receive interest on \$250 million at a variable interest rate that is based upon the one-month LIBOR rate.

In January 2016, Kindred entered into three interest rate swap agreements to hedge its floating interest rate on an aggregate of \$325 million of debt outstanding. The interest rate swaps had an effective date of January 11, 2016, and were set to expire on January 9, 2021. Kindred was required to make payments based upon a fixed interest rate of 1.862% and 1.855% calculated on the notional amount of \$175 million and \$150 million, respectively. In exchange, Kindred received interest on \$325 million at a variable interest rate that was based upon the three-month LIBOR, subject to a minimum rate of 1.0%. In connection with the Kindred Reorganization, these interest rate swap agreements were settled in June 2018 by the Predecessor Company resulting in a pretax gain of \$9.9 million.

The interest rate swap was assessed for hedge effectiveness for accounting purposes and the Company determined the interest rate swap qualifies for cash flow hedge accounting treatment at December 31, 2018. The Company uses the private company simplified hedge accounting standard and records the effective portion of the gain or loss on derivative financial instruments in accumulated other comprehensive income (loss) as a component of members' equity and records the ineffective portion of the gain or loss on derivative financial instruments as interest expense. There was no ineffectiveness related to the interest rate swap for the Successor Company.

At December 31, 2018, the fair value of the interest rate swap was recorded in other current liabilities for \$7.1 million. The fair value was determined by reference to a third party valuation and is considered a Level 2 input within the fair value hierarchy (as described in Note 15).

NOTE 11 – CONTINGENCIES

Management continually evaluates contingencies based upon the best available information. In addition, allowances for losses are provided currently for disputed items that have continuing significance, such as certain third party reimbursements and deductions that continue to be claimed in current cost reports and tax returns.

Management believes that allowances for losses have been provided to the extent necessary and that its assessment of contingencies is reasonable.

Principal contingencies are described below:

Revenues – Certain third party payments are subject to examination by agencies administering the various reimbursement programs. The Company is contesting certain issues raised in audits of prior year cost reports and the denial of payment by third parties to the Company's customers.

Professional liability risks – The Company has provided for losses for professional liability risks based upon management's best available information including actuarially determined estimates. Ultimate claims costs may differ from the provisions for loss. See Note 7.

Legal and regulatory proceedings – The Company is a party to various legal actions and regulatory and other governmental and internal audits and investigations in the ordinary course of business (including investigations resulting from the Company's obligation to self-report suspected violations of law). The Company cannot predict the ultimate outcome of pending litigation and regulatory and other governmental and internal audits and investigations. The U.S. Department of Justice (the "DOJ"), the Centers for Medicare and Medicaid Services ("CMS") or other federal and state enforcement and regulatory agencies may conduct additional investigations related to the Company's businesses in the future. These matters could potentially subject the Company to sanctions, damages, recoupments, fines, and other penalties (some of which may not be covered by insurance), which may, either individually or in the aggregate, have a material adverse effect on the Company's business, financial position, results of operations, and liquidity. See Note 16.

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 11 – CONTINGENCIES (Continued)

Other indemnifications – In the ordinary course of business, the Company enters into contracts containing standard indemnification provisions and indemnifications specific to a transaction, such as a disposal of an operating facility. These indemnifications may cover claims related to employment-related matters, governmental regulations, environmental issues and tax matters, as well as patient, third party payor, supplier and contractual relationships. The Company also is subject to indemnity claims under contracts with its Kindred Rehabilitation Services division customers related to the provision of its services. Obligations under these indemnities generally are initiated by a breach of the terms of a contract or by a third party claim or event. These indemnifications could potentially subject the Company to damages and other payments which may, either individually or in the aggregate, have a material adverse effect on the Company’s business, financial position, results of operations or liquidity.

Income taxes – The Company is subject to various federal and state income tax audits in the ordinary course of business. Such audits could result in increased tax payments, interest and penalties.

NOTE 12 – CAPITAL STOCK AND SHARE-BASED COMPENSATION

Capital stock

As part of the Kindred Reorganization, the majority of the shares of Kindred Common Stock, unvested service-based restricted shares and unvested performance-based restricted shares were paid out in cash at \$9.00 per share. The unearned compensation expense for unvested service-based restricted shares and unvested performance-based restricted shares totaling \$10.5 million as of June 30, 2018 were written off as a restructuring charge in the Successor Company statement of operations.

Former shareholders owning 6.9 million shares of Kindred Common Stock have not been paid due to pending litigation. See Note 16. The Company has an accrual related to these pending payments totaling \$62.0 million as of December 31, 2018 in other accrued liabilities in the accompanying consolidated balance sheet. In addition, certain Kindred employees owning 0.6 million shares of Kindred Common Stock have not been paid out at \$9.00 per share. The payouts will occur under the original vesting of the unvested service-based restricted shares and unvested performance-based restricted shares programs. The Company has an accrual totaling \$5.5 million as of December 31, 2018 in other accrued liabilities in the accompanying consolidated balance sheet related to these pending employee payouts.

The Predecessor Company financial statements reflect compensation expense related to unvested service-based restricted shares and unvested performance-based restricted shares totaling \$5.2 million and \$1.4 million, respectively.

Service-vesting profit units

The Successor Company implemented a service-vesting profit unit plan in 2018. Service-vesting profit units primarily vest ratably over a five-year period.

At December 31, 2018, unearned compensation costs related to non-vested service-vesting profit units aggregated \$5.0 million and are reported in the accompanying consolidated balance sheet as a component of members’ investment. These costs will be expensed over the remaining weighted average vesting period of 4 years. Compensation expense for the Successor Company related to these awards approximated \$0.5 million in 2018.

A summary of non-vested service-vesting profit units follows:

	<u>Non-vested service-vesting profit units</u>	<u>Weighted average fair value at date of grant</u>
Balances, July 2, 2018	–	\$ –
Granted	15,430,588	0.36
Balances, December 31, 2018	<u>15,430,588</u>	\$ 0.36

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 12 – CAPITAL STOCK AND SHARE-BASED COMPENSATION (Continued)

Service-vesting profit units (Continued)

The following is a summary of the significant assumptions used in estimating the fair value of service-vesting profit units granted in 2018:

	2018
Assumptions:	
Risk-free interest rate	2.83%
Expected volatility	35.46%
Expected term	7 years

The risk-free interest rate is based upon published data on U.S. Treasuries that match the term of the award. Expected volatility was estimated using the average volatility of the Successor Company’s peers. Expected term is based on a typical option expected life.

MOIC-vesting profit units

The Successor Company implemented a multiple of invested capital (“MOIC) vesting profit unit plan in 2018. Compensation expense will not be recognized by the Successor Company until it is probable that a covered transaction (a performance condition) will occur.

A summary of non-vested MOIC-vesting profit units follows:

	Non-vested MOIC-vesting profit units
Balances, July 2, 2018	–
Granted	10,654,056
Balances, December 31, 2018	10,654,056

NOTE 13 – EMPLOYEE BENEFIT PLANS

The Company maintains defined contribution retirement plans covering employees who meet certain minimum eligibility requirements. Benefits are determined as a percentage of a participant’s contributions and generally are vested based upon length of service. Retirement plan expense for employees of the Company was \$1.5 million for both the Successor Company and the Predecessor Company. Amounts equal to retirement plan expense are funded annually.

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 14 – BALANCE SHEET INFORMATION

Supplemental information related to the accompanying consolidated balance sheet at December 31 follows (in thousands):

	Successor Company
	2018
Other current assets:	
Prepaid assets	\$ 27,721
KAH receivable – malpractice and workers compensation	8,958
KAH receivable – TSA and other miscellaneous (see Note 17)	5,737
Receivable from sale of equipment	4,167
Other	1,373
	\$ 47,956
Other long-term assets:	
Reinsurance and other recoverables	\$ 148,723
Funds in escrow	17,158
KAH receivable – malpractice and workers compensation	15,699
Cost-method investments	15,000
Receivable from sale of equipment	12,153
Other	29,847
	\$ 238,580
Other accrued liabilities:	
Dissenting shares (see Note 12)	\$ 62,033
Sale-leaseback financing obligation related to the SNF Divestiture (see Note 3)	53,054
Patient accounts	52,173
Taxes other than income	22,902
Accrued acquisition and divestiture costs	12,529
Other	27,650
	\$ 230,341
Deferred credits and other liabilities:	
Leasehold interest liabilities	\$ 248,175
Accrued workers compensation	78,418
Accrued lease termination fees	44,813
Other	39,024
	\$ 410,430

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 15 – FINANCIAL INSTRUMENTS AND FAIR VALUE MEASUREMENTS

The Company follows the provisions of the authoritative guidance for fair value measurements, which addresses how companies should measure fair value when they are required to use a fair value measure for recognition or disclosure purposes under GAAP.

Fair value is defined as the exchange price that would be received for an asset or paid to transfer a liability in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. The guidance related to fair value measures establishes a fair value hierarchy that requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The guidance describes three levels of inputs that may be used to measure fair value:

- Level 1** Quoted prices in active markets for identical assets or liabilities. Level 1 assets and liabilities include debt and equity securities and derivative contracts that are traded in an active exchange market, as well as certain U.S. Treasury, other U.S. Government and agency asset backed debt securities that are highly liquid and are actively traded in over-the-counter markets.
- Level 2** Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, and other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.
- Level 3** Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities. Level 3 assets and liabilities include financial instruments whose value is determined using pricing models, discounted cash flow methodologies, or similar techniques, as well as instruments for which the determination of fair value requires significant management judgment or estimation.

The Company's assets and liabilities measured at fair value on a recurring basis and any associated losses for the year ended December 31, 2018 are summarized below (in thousands):

	<u>Fair value measurements</u>			<u>Assets/liabilities at fair value</u>	<u>Total losses</u>
	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>		
December 31, 2018					
Recurring:					
Assets:					
Money market funds	\$ 1,050	\$ –	\$ –	\$ 1,050	\$ –
Deposits held in money market funds	110	–	–	110	–
	<u>\$ 1,160</u>	<u>\$ –</u>	<u>\$ –</u>	<u>\$ 1,160</u>	<u>\$ –</u>
Liabilities:					
Interest rate swap	\$ –	\$ 7,086	\$ –	\$ 7,086	\$ –

Recurring measurements

The Company's insurance subsidiary's cash and cash equivalents of \$31.6 million as of December 31, 2018, classified as insurance subsidiary investments, is maintained for the payment of claims and expenses related to professional liability and workers compensation risks.

The Company had money market funds totaling \$1.1 million as of December 31, 2018 related to a deferred compensation plan that is maintained for certain of the Company's current and former employees.

The Company's deposits held in money market funds consist primarily of cash and cash equivalents for the Company's general corporate purposes.

The fair value of the derivative asset or liability associated with the interest rate swap is estimated using industry-standard valuation models, which are Level 2 measurements. Such models project future cash flows and discount the future amounts to a present value using market-based observable inputs, including interest rate curves. See Note 10.

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 15 – FINANCIAL INSTRUMENTS AND FAIR VALUE MEASUREMENTS (Continued)

Recurring measurements (Continued)

The following table presents the carrying amounts and estimated fair values of the Company’s financial instruments. The carrying value is equal to fair value for financial instruments that are based upon quoted market prices or current market rates. The Company’s long-term debt is based upon Level 2 inputs.

<u>(In thousands)</u>	December 31, 2018	
	Carrying value	Fair value
Cash and cash equivalents	\$ 84,213	\$ 84,213
Insurance subsidiary investments	31,613	31,613
Long-term debt, including amounts due within one year (excluding capital lease obligations totaling \$0.1 million at December 31, 2018)	460,090	444,924

NOTE 16 – LEGAL AND REGULATORY PROCEEDINGS

The Company provides services in a highly regulated industry and is subject to various legal actions and regulatory and other governmental and internal audits and investigations in the ordinary course of business (including investigations resulting from the Company’s obligation to self-report suspected violations of law). These matters could (1) require the Company to pay substantial damages, fines, penalties or amounts in judgments or settlements, which individually or in the aggregate could exceed amounts, if any, that may be recovered under the Company’s insurance policies where coverage applies and is available; (2) cause the Company to incur substantial expenses; (3) require significant time and attention from the Company’s management; (4) subject the Company to sanctions, including possible exclusions from the Medicare and Medicaid programs; and (5) cause the Company to close or sell one or more facilities or otherwise modify the way the Company conducts business. The ultimate resolution of these matters, whether as a result of litigation or settlement, could have a material adverse effect on the Company’s business, financial position, results of operations, and liquidity.

In accordance with authoritative accounting guidance related to loss contingencies, the Company records an accrued liability for litigation and regulatory matters that are both probable and reasonably estimable. Additional losses in excess of amounts accrued may be reasonably possible. The Company reviews loss contingencies that are reasonably possible and determines whether an estimate of the possible loss or range of loss, individually or in aggregate, can be disclosed in the Company’s consolidated financial statements. These estimates are based upon currently available information for those legal and regulatory proceedings in which the Company is involved, taking into account the Company’s best estimate of losses for those matters for which such estimate can be made. The Company’s estimates involve significant judgment and a variety of assumptions, given that (1) these legal and regulatory proceedings may be in early stages; (2) discovery may not be completed; (3) damages sought in these legal and regulatory proceedings can be unsubstantiated or indeterminate; (4) the matters often involve legal uncertainties or evolving areas of law; (5) there are often significant facts in dispute; and/or (6) there is a wide range of possible outcomes. Accordingly, the Company’s estimated loss or range of loss may change from time to time, and actual losses may be more or less than the current estimate. At this time, except as otherwise specifically noted, no estimate of the possible loss or range of loss, individually or in the aggregate, in excess of the amounts accrued, if any, can be made regarding the matters described below.

Set forth below are descriptions of the Company’s significant legal proceedings.

Medicare and Medicaid payment reviews, audits, and investigations—As a result of the Company’s participation in the Medicare and Medicaid programs, the Company faces and is currently subject to various governmental and internal reviews, audits, and investigations to verify the Company’s compliance with these programs and applicable laws and regulations. The Company is routinely subject to audits under various government programs, such as the CMS Recovery Audit Contractor program, in which third party firms engaged by CMS conduct extensive reviews of claims data and medical and other records to identify potential improper payments to healthcare providers under the Medicare program. In addition, the Company, like other healthcare providers, is subject to ongoing investigations by the OIG, the DOJ and state attorneys general into the billing of services provided to Medicare and Medicaid patients, including whether such services were properly documented and billed, whether services provided were medically necessary, and general compliance with conditions of participation in the Medicare and Medicaid programs. Private pay sources such as third party insurance and managed care entities also often reserve the right to conduct audits. The Company’s costs to respond to and defend any such reviews, audits, and investigations are significant and are likely to increase in the current enforcement environment. These audits and investigations may require the Company to refund or retroactively adjust amounts that have been paid under the relevant government program or by other payors. Further, an adverse review, audit, or investigation also could result in other adverse consequences, particularly if the underlying conduct is found to be pervasive or systemic. These consequences include (1) state or federal agencies imposing fines, penalties, and

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 16 – LEGAL AND REGULATORY PROCEEDINGS (Continued)

other sanctions on the Company; (2) loss of the Company's right to participate in the Medicare or Medicaid programs or one or more third party payor networks; (3) indemnity claims asserted by customers and others for which the Company provides services; and (4) damage to the Company's reputation in various markets, which could adversely affect the Company's ability to attract patients, customers and employees.

Whistleblower lawsuits—The Company is also subject to *qui tam* or “whistleblower” lawsuits under the federal False Claims Act and comparable state laws for allegedly submitting fraudulent bills for services to the Medicare and Medicaid programs. These lawsuits can result in monetary damages, fines, attorneys' fees, and the award of bounties to private *qui tam* plaintiffs who successfully bring these lawsuits and to the respective government programs. The Company also could be subject to civil penalties (including the loss of the Company's licenses to operate one or more facilities or healthcare activities), criminal penalties (for violations of certain laws and regulations), and exclusion of one or more facilities or healthcare activities from participation in the Medicare, Medicaid, and other federal and state healthcare programs. The lawsuits are in various stages of adjudication or investigation and involve a wide variety of claims and potential outcomes.

Employment-related lawsuits—The Company's operations are subject to a variety of federal and state employment-related laws and regulations, including but not limited to the U.S. Fair Labor Standards Act, Equal Employment Opportunity laws, and enforcement policies of the Equal Employment Opportunity Commission, the Office of Civil Rights and state attorneys general, federal and state wage and hour laws, and a variety of laws enacted by the federal and state governments that govern these and other employment-related matters. Accordingly, the Company is currently subject to employee-related claims, class actions and other lawsuits and proceedings in connection with the Company's operations, including but not limited to those related to alleged wrongful discharge, illegal discrimination, and violations of equal employment and federal and state wage and hour laws. Because labor represents such a large portion of the Company's operating costs, noncompliance with these evolving federal and state laws and regulations could subject the Company to significant back pay awards, fines, and additional lawsuits and proceedings. These claims, lawsuits, and proceedings are in various stages of adjudication or investigation and involve a wide variety of claims and potential outcomes.

Shareholder actions— Six purported class action complaints related to the Merger were filed on behalf of putative classes of Kindred's public stockholders (the “Merger Complaints”). Four of these complaints were filed in the United States District Court for the District of Delaware: *Sehrgosha v. Kindred Healthcare, Inc., et al.*, filed on February 8, 2018; *Carter v. Kindred Healthcare, Inc., et al.*, filed on February 14, 2018; *Rosenfeld v. Kindred Healthcare, Inc., et al.*, filed on February 15, 2018; and *Einhorn v. Kindred Healthcare, Inc., et al.*, filed on February 21, 2018. The remaining two complaints were filed in the United States District Court for the Western District of Kentucky: *Tompkins v. Kindred Healthcare, Inc., et al.*, filed on February 9, 2018; and *Buskirk v. Kindred Healthcare, Inc., et al.*, filed on February 13, 2018. Kindred and individual members of the board of directors are named as defendants in each of the actions. The *Tompkins* action also names as defendants TPG, WCAS, Humana, Parent, HospitalCo Parent and Merger Sub. The Merger Complaints generally allege that the defendants violated the Securities Exchange Act of 1934, as amended, by failing to disclose material information in Kindred's preliminary proxy statement filed on February 5, 2018. The Merger Complaints seek, among other things, injunctive relief prohibiting the stockholder vote to approve the Merger and unspecified compensatory damages and attorneys' fees. On March 5, 2018, the plaintiffs jointly agreed to voluntarily dismiss the Merger Complaints in exchange for Kindred's agreement to file supplemental disclosures with the Securities and Exchange Commission. The supplemental disclosures were filed on March 6, 2018. The issue of an associated award of legal fees has fully briefed to the court. The parties have reached a tentative settlement of \$0.4 million on the award of legal fees.

During March 2018, Kindred received notices from 21 of its former shareholders, holding 8,120,003 shares of Common Stock in the aggregate, indicating their election to seek statutory appraisal of their shares of Common Stock instead of accepting the Merger Consideration of \$9 per share. Seventeen of the 21 former shareholders, holding 1,227,401 shares in the aggregate, subsequently elected to accept the Merger Consideration and forego appraisal of their respective shares. On July 31, 2018, the remaining former shareholders, including Brigade Leveraged Capital Structures Fund Ltd., Brigade Calvary Fund Ltd. and Brigade Distressed Value Master Fund Ltd., filed a complaint in the Court of Chancery of the State of Delaware seeking appraisal rights for 6,892,602 shares of Common Stock. The Company disputes the allegations in the complaint and will defend this lawsuit vigorously.

KINDRED HEALTHCARE, LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 16 – LEGAL AND REGULATORY PROCEEDINGS (Continued)

Ordinary course matters—In addition to the matters described above, the Company is subject to investigations, claims, and lawsuits in the ordinary course of business, including investigations resulting from the Company's obligation to self-report suspected violations of law and professional liability claims, particularly in the Company's hospital operations and former nursing center operations. In many of these claims, plaintiffs' attorneys are seeking significant fines and compensatory and punitive damages in addition to attorneys' fees. The Company maintains professional and general liability insurance in amounts and coverage that management believes are sufficient for the Company's operations. However, the Company's insurance may not cover all claims against the Company or the full extent of its liability.

NOTE 17 – RELATED PARTY TRANSACTIONS

Support center allocations

The Predecessor Company provided certain support functions to KAH on a centralized basis, including cash management, accounts receivable processing, property and equipment record keeping, accounts payable processing, payroll and general bookkeeping. The Predecessor Company also managed general business functions on behalf of KAH, including cost reimbursement reporting, human resources, financial reporting and legal services. The Predecessor Company referred to these expenses as support center allocations and have been allocated between the Predecessor Company and KAH based upon a percentage of net revenues. The Predecessor Company allocated expenses of \$53.7 million for January 1, 2018 through July 1, 2018 were charged to KAH, which are presented as a reduction of other operating expenses in the accompanying combined statement of operations of the Predecessor Company.

Intercompany services

The Predecessor Company provided services to KAH mainly related to rehabilitation and hospital services totaling \$1.2 million. The income is recorded in revenues in the accompanying combined statement of operations.

Transition services agreement

As part of the Merger, the Company entered into a transition services agreement with KAH to provide information system services and various transition services such as payroll, marketing, government affairs and income taxes. The Company recorded \$24.6 million in other income in the Successor Company accompanying consolidated statement of operations.

Sponsor fees and value capture initiatives

As part of the Merger, the Company entered into management services agreements with TPG and WCAS. As part of these agreements, the Company is required to pay each a monthly fee. These fees totaled \$1.9 million in the Successor Company accompanying consolidated statement of operations.

The Company is also required to pay third party consultants and vendors related to various value capture initiatives which are expected to generate future cost savings. The expense for these third party consultants and vendors totaled \$6.2 million in the Successor Company accompanying consolidated statement of operations.